Multiple Exclusion Homelessness, attachment and relationship with care: A missing link?

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ABSTRACT

The overlap of issues experienced by those at the sharp end of society in conjunction with the absence of a comprehensive framework for meeting the needs of these severely disadvantaged individuals is evident in existing literature. Sporadic and uncoordinated encounters, premature disengagement, and difficult interactions between service users and support staff are commonly reported by support service providers. Childhood adversity, mental health difficulties, substance misuse and other experiences of social exclusion are prevalent within the homeless population and affect their relationship with support. This study argues that a focus on attachment can produce valuable insights into why and how people with experience of Multiple Exclusion Homelessness (MEH) relate to services in ways that can often be challenging for staff.

The study set out to examine the attachment styles and relating patterns of individuals with experience of MEH when engaging with support services. It further aimed to look into staff members' emotional and cognitive responses to people with complex needs and insecure attachments. A total of 30 participants who had experience MEH were interviewed and four focus groups involving a total of 19 front-line staff members were conducted. Service users' attachment styles, the degree of insecurity, the quality of the support context and the ability to access support in times of need were assessed through a standardised interview (Attachment Style Interview). Follow-up interviews and questionnaires looked at the relationship with support services and adversity in early and later life. Finally, a vignette technique was applied to focus attention on four highly insecure attachment styles that staff members come across in their daily work.

Results showed that the dual/disorganised attachment style was the most prevalent (n=22), and the support context and quality of close relationships was found to be particularly poor amongst participants with experience of MEH. Further analysis revealed that attachment processes limited the capacity for healthy functioning, whilst also being an important influence upon interactions between staff and service users. These findings highlight the potential utility of an attachment-based approach in homeless services, and indicate that understating service users' attachment styles allows for prediction of and more effective responses to likely patterns of interaction in these settings.

To my beloved father and grandmother who are
no longer here to see the end of this work

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Chapter 1: Introduction

There is growing awareness in academic and policy circles that there is a considerable overlap of issues experienced by those at the 'sharp end' of society (Fitzpatrick et al., 2011; DWP, 2012), including homelessness and street culture activities, drug and alcohol misuse, poor mental health and criminal offending. The co-occurrence of homelessness with experiences such as substance misuse, institutional care and street culture activities has recently been defined as Multiple Exclusion Homelessness (MEH) (Cornes et al., 2011; Fitzpatrick et al., 2012; Fitzpatrick et al., 2013). In a similar vein, the term Severe and Multiple Disadvantage (SMD) has been used to describe the coexistence of homelessness, offending and substance misuse (McDonagh, 2011; Duncan & Corner, 2012; Bramley et al., 2015). In England it was estimated that each year (2010/11 was selected as the optimal year), over a quarter of a million people have contact with at least two out of three of the homelessness, substance misuse and/or criminal justice systems, and at least 58,000 people have contact with all three (Bramley et al., 2015). For instance, around 586,000 individuals received services across the three domains over the course of 2010/11 in total (MHCLG, 2018, 2019; Bramley et al., 2015). In Scotland, numbers are also high with a total of around 875,000 people having a relevant experience across three 'core' domains of SMD (homelessness, substance dependency and offending) over the course of their adult lives, with homelessness being by far the most common experience (Bramley et al., 2019). These populations create significant financial costs for public services and society, and have prompted pervasive calls for more effective interventions (Bramley et al., 2015, 2019).

Tackling homelessness, and responding to the needs of the most 'entrenched' rough sleepers and supporting people with 'complex needs' in particular, has been the focus of recent policy development in the UK (Homelessness and Rough Sleeping Action Group, 2018). Promoting and sustaining long-term independent living and minimising social exclusion is a key target for policies and agencies involved in supporting these populations. However, as a recent review conducted by Shelter (2016, p. 25) acknowledges: *"generally services are not designed for the disengaged, for the socially excluded or for people with relational difficulties"*. Indeed, considerable challenges have been noted by service providers in engaging and establishing effective and positive relationships with service users presenting with a range of complex needs. As a response, there has been a surge of interest in developing service interventions that are better designed to meet the needs of these vulnerable populations, with personalized support packages and flexible approaches

often underpinning their work (MHCLG, 2015; Housing and Social Justice Directorate, 2018).

Existing evidence indicates that the majority of people in these populations have also been subject to childhood adversity and multiple traumas over their lives (see Fitzpatrick et al., 2013). Such individuals are often labelled as 'service resistant' or 'difficult to engage' and exhibit a number of behaviours that frequently characterised as 'chaotic' (Dwyer and Somerville, 2011). Building upon existing scholarship, this study uses insights from attachment theory to further develop understanding of individuals' pathways into MEH and their manner of interacting with support services. It argues that attachment can offer a comprehensive framework for meeting the needs and addressing both problematic individual behaviour and any lack of social-emotional skills that may be expressed by the most disadvantaged individuals. These insights offer substantial potential to inform service delivery for this vulnerable population.

1.1 Rationale of the study

Existing research places great emphasis on the particular demographic traits and other characteristics of MEH populations and strongly indicates that those populations typically have significant disadvantage and trauma histories in early life (Walter, 2016). Literature suggests that the type and frequency of early traumatic experiences strongly influences the relational functioning in adulthood in a variety of ways, especially in close relationships and overall styles of relating. This study draws upon a well-developed field of psychology and suggests that the concept of attachment can produce valuable insights into how and why individuals with experience of MEH relate to services in ways that can often be challenging for staff. The difficulties service providers face in responding to the needs of this population are evidenced in literature but the actual psycho-mechanics underpinning those behaviours and responses remain poorly understood.

The volume of research on adult attachment in traumatised populations has increased significantly over recent years, demonstrating how early and later attachments affect relationships, behaviour and coping skills in childhood and beyond. The attachment styles are associated with present behaviour, the strategies employed to cope with adversity and the skills for regulating emotions (Bowlby, 1969; Mikulincer & Shaver, 2007). Consequently, supportive relationships, either personal or professional ones, are impacted by secure or insecure attachment styles. In adults experiencing homelessness and a range of co-occurring substance misuse and mental health issues, the difficulty in building trustful relationships creates significant barriers for recovery (Klop et al., 2018). Sporadic and

uncoordinated encounters, premature disengagement and difficult interactions between service users and support staff are commonly reported by service providers (Clinks et al., 2009; MEAM, 2009). These are considered to be key barriers to effective care, with negative consequences for both service users and support staff.

Building upon this, this project suggests that those incoherent ways of engaging with support could be explained as an attempt to attain self-regulation and a sense of security that was not previously met by attachment figures. This is based on the idea that historical and current attachment experiences might be one factor that influence present relating patterns but it is a significant one for gaining insight into how professionals might work more effectively with 'hard to reach' populations (Adshead, 2002; Berry et al., 2008).

1.2 Definition of terms

The population of interest in this study includes individuals with experience of *Multiple Exclusion Homelessness* (MEH). Following recent research in the UK (Fitzpatrick et al., 2011; Fitzpatrick et al., 2013), the definition of MEH used here is as follows: people have experienced MEH if they have been 'homeless' (including experience of temporary/unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following additional domains of deep social exclusion – 'institutional care' (prison, local authority care, psychiatric hospitals or wards); 'substance misuse' (drug problems, alcohol problems, abuse of solvents, glue or gas), or participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work).

Complex trauma is another concept that is crucial to the study. The term was introduced by Herman (1992) and refers to the psychological harm arising from repeated and sustained trauma, usually over a period of time and within 'specific relationships and contexts'. This exposure results not solely to the development of post-traumatic stress disorder (PTSD) symptoms but to a constellation of interpersonal disturbances. Those experiences leave the person feeling helpless, powerless, unsafe and out of control, and can have significant effects on physical, mental and spiritual development (Courtois, 2008).

The study draws very strongly upon *attachment theory*. Attachment theory is a psychological model that was developed by John Bowlby in the 1960s. Bowlby (1969, p. 194) defined attachment as "a lasting psychological connectedness between human beings" and he proposed that it can be understood within an evolutionary context. The theory attempts to describe the dynamics of long-term and short-term relationships, explain the inner mechanisms of social bonding, the influences of past experiences in establishing

relationships with others, and the role of attachment as a stress buffer (Bowlby, 1969; Mikulincer & Shaver, 2007).

The concept of *attachment styles* is central to attachment theory. As used in this study, the term refers to both the internal models that guide interpersonal behaviour and information processing and to the characteristic strategies that individuals use to maintain felt security (Hazan & Shaver, 1987). A number of models of attachment style are described in existing scholarship, but the insecure styles focussed on in this study include secure, angry-dismissive, enmeshed, withdrawn, fearful and dual/disorganised (Bifulco et al., 2014).

The term *disorganised attachment* is considered to be a distinct theoretical construct and a number of ambiguities of communication in shaping interpretations of the concept of disorganised attachment have been noted in literature (see Reijman, Foster & Duschinsky, 2018). In this study, disorganised attachment is not seen as a diagnostic label for assessment of risk. It rather adopts Mikulincer and Shaver's (2016, p. 143) description of disorganised attachment as *"random fluctuations"* of behaviour and Crittenden's (1997) definition who suggested that such behaviours are showing "organized" combinations of avoidant and resistant attachment strategies. The rationale underpinning this particular formulation is described in detail in Chapter four.

1.3 Thesis aim and research questions

The overall aim of this study is to identify the attachment styles of people with experience of MEH, consider the potential influence of those styles on their pathway into MEH, and reflect on the impact of those styles on their relationships with professional support staff. In particular, the project sheds light on and defines the psychological mechanisms which underpin the current relating processes of individuals with experience of MEH. It further investigates the links between homelessness and behaviours stemming from psychological trauma, specifically the associations between attachment styles, trauma and responses to support and care. Understanding the attachment styles of service users allows for better prediction of likely patterns and problems in their interactions with professionals. In this vein, the study further seeks to explore staff-related factors upon the relationships that develop and in particular their cognitive and emotional reactions towards so-called 'difficult to engage' service users. Previous research has neglected staff members' experiences and contributions to those interactions, and this study seeks to address this gap.

To address this aim, four research questions were developed which provided a guide for the design and implementation of the project. Those are as follows:

1. What are the attachment styles exhibited by individuals that have experience of multiple exclusion homelessness?
2. What (if any) influence does adult attachment have on pathways into multiple exclusion homelessness?
3. How do attachment styles influence their relationship with staff members in front-line support services?
4. What are the cognitive and emotional responses of staff members towards service users with insecure attachment styles?

The first question allows for identification of the attachment styles exhibited by individuals who have experience of MEH. It is envisaged that doing so will contribute to an understanding of challenging behaviours and their function, while it can assist in explaining the different styles of recovery and engagement with services. The second research question examines the potential influence of those attachment styles on individuals' pathways into MEH. Attachment styles themselves shape current responses to services, and when highly insecure, severely impact on an individual's ability to trust and seek help. Poor social networks, inability to form supportive relationships, isolation and inability to trust can be regarded as risk factors for homelessness and as factors inhibiting a route out of homelessness. The influence of a poor and insecure attachment climate as a potential contributing factor to homelessness has not been explored to date.

The third question explores the impact of those attachment styles on the relationship between MEH individuals and staff members working in front-line homeless services. Focus is directed upon 'difficult service user/support staff interactions' rather than on 'difficult to engage individuals'. Finally, the fourth research question reflects on staff members' emotional and cognitive responses towards service users with highly insecure attachment styles. These are intended to offer insights that might be used to inform practice, given evidence that service users' insecure attachment styles can elicit strong reactions and make it very difficult for staff to understand and respond constructively to service users' interpersonal needs. All four research questions are further discussed in the methodology chapter.

1.4 Methods

In addressing these research questions, the thesis draws on data emerging from interviews, questionnaires and focus group discussions. A total of 30 individuals with experience of MEH took part in the Attachment Style Interview (ASI) which was used to assess their attachment style. After the ASI, these interviewees also participated in a brief semi-structured qualitative interview which provided an in-depth account of their relationship with care and explored the influence of attachment experience on their pathway into MEH. For descriptive purposes, a demographic questionnaire (which also included questions related to experience of each of the domains of MEH), a life event questionnaire and the Adverse Childhood Experience (ACE) questionnaire were also completed. Finally, a set of four focus groups with front line support staff involving the use of vignettes to focus discussions were conducted. Data were collected via these means within four homelessness agencies in two Scottish cities.

This is the first time that the ASI has been used with a sample of homeless individuals. The ASI is a relatively new assessment of attachment compared to other well-established measures. It differs substantially from other attachment measures in that it lends itself to a more social approach and uses a contextualised, support-focused approach to assess interpersonal behaviour and attitudes while establishing current attachment styles according to standard types. In contrast to all other measures, ASI also offers the capacity to measure the degree of insecurity and assess the participant's specific support context and quality of close relationships. It oscillates between a directive and non-directive style, and fully adapts to an individual respondent's style, thus was deemed appropriate given the vulnerability of the sample.

1.5 Thesis outline

The thesis is structured as follows. Chapter 2 reviews literature regarding the risks and characteristics of MEH and looks into the links between trauma and homelessness. It further reviews the policy and practice responses towards service users with complex needs who appear less motivated to seek help and/or take longer to engage. Chapter 3 focuses on the key tenets of attachment theory and critically reviews the notion of attachment and its relevance to trauma. A review of attachment literature and what is known about its links to homelessness is provided. Chapter 4 documents the methodology of the study. Research methods are critically analysed and justified in light of recent methodological developments in the field. This also outlines the way that data are analysed and how

analysis is informed by a critical realist perspective, seeking to examine the underlying casual relations between homelessness and attachment.

Chapters 5 to 8 present the analysis of empirical data and discussion of how findings link to, and advance, existing scholarship. Those have been structured in accordance with the research objectives, thus chapter 5 introduces the descriptive and socio-demographic findings of interviews with people who have experience of MEH. It provides a detailed account of participants' attachment styles, the degree of their insecurity, and ability to make and maintain relationships, as well as their adverse childhood experiences. In turn, chapter 6 focuses on answering the second research question of the study, which looks into the role of attachment in the causation of MEH. This explores the generative mechanisms that may cause the phenomenon of homelessness to occur and the processes and conditions under which individuals have found themselves homeless.

The qualitative analysis of the interviews is discussed in chapter 7. It provides an in-depth discussion of participants' patterns of behaviour and strategies when engaging with support, while it also explores the role of self and others for developing positive interactions. Finally, chapter 8 draws on data from the focus groups with front-line workers and explores how staff members make sense of the behavioural and emotional patterns of their service users and how they tend to respond to challenging behaviours. The thesis concludes in chapter 9 by drawing together the study's key conclusions and reflects on its strengths, weaknesses and limitations. The implications for policy and practice are considered and suggestions for further research are made.

CHAPTER 2: Multiple Exclusion Homelessness and Complex Trauma

Introduction

This, the first of two literature review chapters, gives an overview of what is documented about the characteristics and needs of the population of focus. It begins by reviewing definitions of homelessness generally and MEH in particular. It then reflects on what is known about the causes of and risk factors for MEH, and especially the links between complex trauma and MEH, before considering the impact of complex trauma on people with experience of MEH. It ends by providing an overview of policy and service responses to MEH populations. The lack of a sophisticated understanding of how best to approach and engage with those at the extreme margins of society is highlighted throughout this review.

2.1 Definitions of homelessness

The debate within housing and social research over how to define homelessness and most importantly capture its complexity is long established (see Fitzpatrick et al., 2000; Rosengard, 2007). It has been argued that homeless is a term that is highly relative depending on perspective (political, social etc.) and imposing a particular definition may undervalue other significant aspects of the phenomenon, or exclude and further marginalise other subcategories of homelessness (Tipple et al., 2005). Jacobs et al. (1999, p. 9) highlighted the challenges inherent in attempts to define homelessness, emphasizing the fact that is a *"politically sensitive concept"* and *"subject to fluctuation at different times, localities and policy agendas"*. In this light, depending on the theoretical approach adopted, context, interests and public policies of interest, definitions may be subject to change.

Overall, it can be said that definitions of homelessness may be identified as falling into *minimalist* or *maximalist* accounts (Jacobs et al., 1999). Definitions following a *maximal* approach tend to be broader in their explanation, often associated with structural macro-level factors such as housing policies and workforce issues. *Minimalist* accounts are far narrower and are often associated with individual failings or actions related to substance misuse and illness (Jacobs et al., 1999). In this vein, McNaughton (2008, p. 4) identified four intersecting (but distinct) dimensions of homelessness, those being; 'absolute' minimal homelessness (i.e. rough sleeping), homelessness related to housing

quality, homelessness as a subjective experience, and homelessness as it relates to statutory definitions.

In an attempt to review the existing types of homelessness in Europe, the European Typology of Homelessness and housing exclusion (ETHOS, 2006) identified four distinct categories: rooflessness (without a shelter of any kind, sleeping rough), houselessness (with a place to sleep but temporary in institutions or shelter), living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence), and living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding).The ETHOS typology provided the base for a recent attempt to conceptualise homelessness at a global level.

In this regard, the Institute of Global Homelessness suggested that an appropriate definition should be able to reflect a high level of commonality across the globe and be considered meaningful at an international level, therefore should encompass: (1) those without any form of accommodation, and (2) those living in temporary or crisis accommodation (Busch-Geertsema et al., 2016). This effort was of particular importance, as definitions were applied to a range of housing situations that were not always reflected in national statutory definitions and varied significantly across countries. For instance, UK's statutory definition refers to people who lack a secure place in that they can legally occupy or not reasonably be able to stay (DCLG, 2013). In the US, the statutory definition narrows it down to those that either sleep rough or use homeless accommodation (Toro, 2007).

Tipple et al. (2005) argued that these 'accommodation oriented' definitions fail to account for the complexity of the phenomenon and it cannot be assumed that homelessness is solely related to not having a house. For instance, definitions based on structural factors such as lack of affordable housing and unemployment often present with a number of sub-categories that in cases have been deemed as too 'literal' and insufficient in describing the issue. In those cases, definitions may only include those sleeping rough or living in short term accommodation. In their study on defining homelessness in developing countries, they used a number of criteria to assess current definitions. Those being; lifestyle, location, permanence of occupation or tenure security, welfare entitlement and housing quality. Although predefined standards proved to be valuable when attempting to adopt a definition, Tipple and colleagues went on to conclude that current definitions do not capture the reality of deprivation and marginalisation. They argued that defining homelessness according to different circumstances seems to be more appropriate that having one universal definition that fits them all (Tipple et al., 2005).

In those definitions, emphasis is placed on explaining homelessness as a state or a process that is more than just not having a roof over one's head. A number of writers focus on the discrimination and exclusion attached to those individuals that often have multiple and complex issues and are deemed as 'chaotic'. In that sense, homelessness is also seen as a prevalent form of social exclusion that can take various forms and include a range of interactive factors (Social Exclusion Unit, 2004; Tipple et al., 2005). According to the Social Exclusion Unit (2004, p. 2), *"social exclusion is what can happen when people (or areas) suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime, poor health and family breakdown"*. Having said that, for instance Leistering and Leibrief (1999) defined homelessness as being socially discriminated on a long term basis and/or lacking material resources, abilities and adequate coping strategies for active social participation. In other words, terms may include the intersection of homelessness and other factors such as substance misuse, institutional care, learning disabilities and street culture activities, such as begging and street drinking (see next section). In this light, research points to more holistic and dynamic approaches when defining and explaining homelessness and related forms of exclusion (Fitzpatrick et al., 2000).

Broadly speaking, homelessness may be defined based on living conditions, type of accommodation, duration and frequency of being homelessness, lifestyle choices as well as its statutory relevance (Springer, 2000). When focused on one-dimensional definitions such as the ones that only address the issue of secure accommodation and do not take into account, for instance, the duration and/or frequency of being homeless, we lose sight of the multidimensionality and complexity of the phenomenon. In this vein, the definitions that tend to be discussed amongst academics tend to be more complex and over-processed, often involving elements of 'emotive and cognitive meaning' (Somerville, 1992). Through those lenses the conception of homelessness is seen in both the broader context of poverty and other environmental stressors and through the specific characteristics, symptoms and needs of this population. The next section discusses more complex definitions which may point to incidents of repetitive and chronic homelessness and acknowledge how the interaction of homelessness and other disadvantages *"drive a cycle of deprivation"* (DWP, 2012, p. 10) which often leads to a deeper form of social exclusion.

2.2 Definitions of complex and extreme forms of exclusion

Currently there is no 'official' definition for the most complex forms of homelessness. Terms such as 'multiple and complex needs', 'severe and multiple disadvantage' (SMD) and 'multiple exclusion homelessness' (MEH) are often applied in literature to describe those experiencing a combination of issues that tend to be profound and severe (for a full review see Rosengard, 2007). Those terms appear to include both the 'breadth', which refers to the multiple interconnected needs that co-occur, and 'depth' of need that defines the intensity and complexity of those needs. It has been advised that due to the number of meanings attached to those terms, it is wiser to think about them as a framework, so as to avoid the risks that come with being stringently bound to a particular definition (Rankin & Regan, 2004). Evidently, the terms are frequently used interchangeably; however certain distinct characteristics may be identified within each term in homeless literature (see below).

In detail, the term SMD is *"used to signify the problems faced by adults involved in the homelessness, substance misuse and criminal justice systems, with poverty an almost universal, and mental ill-health a common, complicating factor"* (Bramley et al., 2015, p. 6). An advantage of this term is that it acknowledges the effect of social nature and social relations on disadvantaged populations and therefore calls for social and political solutions for resolving the issue (Duncan & Corner, 2012). In the *Hard Edges* report Bramley et al. (2015) acknowledge that it is an open term which illustrates the complexity and interlocking nature of reported problems, while it does not necessarily relate to the degree of severity of those events.

'Multiple needs and exclusions' is another common definition that address a subset of the deeply excluded population. The term was primarily used by the Cabinet Office in 2006 and later by the Making Every Adult Matter coalition (MEAM, 2009). It refers to those that *"experience a combination of issues that impact adversely on their lives, are routinely excluded from effective contact with services they need, and tend to lead chaotic lives that are costly to society"* (MEAM, 2009, p. 8). The idea behind this definition was to differentiate those with multiple needs who have access to services from those that fall through the gaps and have limited access to support.

In favour of this definition, many researchers have pointed out the incompatibility between service delivery and chaotic lifestyles (Rosengard, 2007; Fitzpatrick et al., 2013). Nonetheless, the definition was criticized for being rather unclear on many levels. For instance, Dwyer and Somerville (2011) asserted that the term created more problems than

it actually resolved. They argued that it does not clarify what constitutes 'effective contact', what being 'routinely excluded' entails, and what it means to have a 'chaotic life'. However, in their paper they do not propose a better alternative. Furthermore, others have suggested that definitions which do not include the term 'needs' may be preferable, in that they avoid the 'individualising effect' that may lead to pathologizing individuals (Duncan & Corner, 2012).

Finally, the term MEH is widely used within the UK housing and homeless literature to convey the complexity of the dynamic interplay between many different facets of the causes and consequences of homelessness (Homeless Link, 2011). Related reviews suggest that this group has been insufficiently targeted in policy and point to current gaps of knowledge regarding how services can best work with this population (Duncan et al., 2012; Shelter, 2016). The original proponents of the term MEH define it as follows:

> "People have experienced MEH if they have been 'homeless' (including experience of temporary/unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following other 'domains' of deep social exclusion: 'institutional care' (prison, local authority care, mental health hospitals or wards); 'substance misuse' (drug, alcohol, solvent or gas misuse); or participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work)" (Fitzpatrick, et al., 2011, p. 502).

The strong overlap between experiences of more extreme forms of homelessness led to the development of the MEH programme which enabled a number of researchers to examine the interaction between a number of co-occurring variables. Fitzpatrick et al. (2011, 2013) explored key patterns and intersections of homeless populations that are multiply excluded in the UK to provide a detailed account of the nature of their experiences. In particular, the statistical analysis of a census survey involving 1,286 users of low threshold services in six urban locations revealed that there was a high degree of overlap between experiences across four domains: 98% had experiences of homelessness, 70% had misused substances, 62% of the sample had been in institutional care, and 67% were involved in street culture activities (i.e. begging, survival shop lifting, street drinking). The results were striking as almost half of the sample (47%) had experience of all four domains. The fact that multiple domains interplay in the occurrence of deep social exclusion has been consistently noted in literature (Levitas, 2007; Dwyer et al., 2011) but the degree of overlap had not previously been quantified.

Overall, multiplicity of forms of disadvantage is central to all the above definitions. Literature highlights the risk involved in choosing a particular term over another in that by opting for one, another disadvantaged section of the population may not be taken into consideration. However, this project is placing an emphasis on a subset of the homeless population with a number of overlapping issues, without necessarily prioritising a particular problem over any other. The aim is to identify those suffering from deep social exclusion involving not just homelessness but also substance misuse, institutional care and involvement in street culture activities to improve current understandings for informing effective interventions. Thus, the recent emergent concept of MEH which refers to a multiple needs group in the sharpest end of society, is adopted. This subset is exhibiting a particular form of exclusion often referred to as 'deep social exclusion' (Cabinet Office/Social Exclusion Task Force, 2007; Fitzpatrick et al., 2013). The next section reflects on what is known about the causes of homelessness in general, and MEH more specifically.

2.3 Explanations of homelessness

It has become more and more evident that the homeless literature has slowly moved from one-sided views of the causation (structural causes only) of homelessness to multicausal ones. Structural and individual factors appear to interact with one another, whilst they are often guided by successful and unsuccessful policy and practice interventions at a local or/and national level. In a quite extensive Canadian report on homelessness, Gaetz and his colleagues (2014, p. 4) asserted that "*the causes of homelessness reflect an intricate interplay between structural factors (poverty, lack of affordable housing), systems failures (people being discharged from mental health facilities, corrections or child protection services into homelessness) and individual circumstances (family conflict and violence, mental health and addictions)".*

Overall, literature acknowledges poverty as a principal cause of homelessness (see Bramley et al., 2017; 2019 as recent examples) and places particular emphasis on the pre-existing and often defining macro-level factors for homelessness to occur without losing sight of the role of individual circumstances. In particular, the nature of the interaction and the inter-relationships amongst structural and individual variables has been a source of intellectual fascination for a number of researchers for some time (see for example Pleace, 2000; Fitzpatrick, 2005; McNaughton, 2009). For instance, the 'new orthodoxy' paradigm argues that despite the complexity of the causes, individuals coming from socially and economically disadvantaged backgrounds are far more likely to experience homelessness

(Pleace et al., 2008). The limiting structural factors will create the conditions for the development of personal difficulties for the most vulnerable individuals (Pleace, 2000), and respectively individual difficulties and behaviour may increase the likelihood of experiencing homelessness in adverse environments. As O'Flaherty (2004, p. 1) observes, the housing market does not always predict homelessness, but does have a tendency to affect (mostly if not always) those at risk: *"It's having the wrong kind of personal characteristics in the wrong kind of housing market"*. In this analogy, the role of the state in incorporating excluded groups into society (see McDonald & Marsh, 2005) has been highlighted as a critical factor. It has been further argued that structured inequality and poverty do not fully capture the real meaning of the phenomenon as they tend to diminish the role of the state.

This 'new orthodoxy' perceptive has been further challenged by critical realists on the grounds that it lacks *"a clear conceptualization of causation"* on a number of levels (Fitzpatrick, 2005, p. 5). The centrality and unpredictability of human agency in conjunction with the whole range of potential causal factors that interplay in homelessness are profound and pivotal parameters for analysing its causes. In this vein, critical realists acknowledge that poverty is a necessary but not a sufficient condition for homelessness to occur given that that the existence of certain 'tendencies' that cause a phenomenon are not always causing it (Fitzpatrick, 2005; McNaughton, 2009). The focus should rather lie in answering questions such as what is it about particular factors that tend to cause homelessness. The exploration of the underlying mechanisms that produce those social events are crucial for any theorization. The challenge, though, of such a perspective lies in uncovering the numerous and often complex pathways that lead to homelessness (Fitzpatrick, 2005). This level of theorization has not always been taken into account in empirical research, which has tended to be more concerned with identifying risk factors than uncovering the driving mechanisms of the phenomenon under scrutiny.

Regarding this, there is a vast volume of studies examining the risk and protective factors that contribute to homelessness, while others attempt to integrate a number of mediated models for examining the interrelationships of a set of variables (see Stein et al., 2002). Most studies suggest that homelessness is closer to a process rather than a state, in which individuals may move in and out, at any time, under many circumstances (Pleace, 2000). Following from this, the pathway approach has been the most prominent form of analysis in UK homeless literature. This places emphasis on non-linear patterns of transition into homelessness, rather than fixed or standard ones, leading to a dynamic explanation of the phenomenon (see Anderson & Tulloch, 2000; May, 2000; Anderson

&Christian, 2003; Crane et al., 2005; McNaughton, 2008; Ravenhill, 2008; Quilgars et al., 2008; Fitzpatrick et al., 2013; Clapham et al., 2014; Bramley et al., 2015).

The combination of a set of experiences leading to homelessness reconfirms the highly comorbid nature of the phenomenon. A number of individual factors such as, family disruption, adverse childhood experiences, having been involved in institutional care, substance misuse issues, lack of social support and poor mental health have been commonly reported in literature (Crane et al., 2005; McNaughton, 2008; Johnsen & Quilgars, 2009; Jones & Pleace, 2010; Fitzpatrick et al., 2013; Mayock & Corr, 2013; Brown et al., 2016). However, the nature of some of those characteristics has been noted as being relative and dependant. For instance, while some might increase an individual's susceptibility to homelessness (e.g. substance misuse), others may have a buffering effect (e.g. family structure, gender). In that sense an exploration of risk factors in a simplistic form has little if any real value but it rather presents dangers of its own, by potentially exacerbating stigma and/or leading to investment in unsuccessful preventative interventions (Brown et al., 2012).

It is worth noting that although this study does not aim to develop a theoretically robust account of the mechanisms through which individual and structural factors interact, it is within its remits to explore the underlying individual mechanisms that affect homelessness. In particular, the interest of this project centres around unravelling the effects of individual psychosocial risk factors for extreme forms of homelessness. In this light, reflections on the complex interaction between structural and individual causes, without though imposing any linear models of their interrelationship, are provided. Individual characteristics, such as gender, substance misuse and mental health can affect susceptibility to homelessness under certain contextual conditions, but more importantly the developing interrelationships amongst those characteristics could provide a more accurate explanation of why this is.

Overall it can be said that models of causal pathways suggest that in most cases there is an accumulation of events prior to homelessness with childhood trauma, mental health and problematic familial relationships being a cluster of factors regularly reported. This finding has been supported and re-affirmed by a number of studies that focused on qualitative aspects of individuals' experiences (Dwyer et al., 2011; Cornes et al., 2011; Bowpitt et al., 2011; Brown et al., 2012). Most of those studies gave a personal account of the pathways into homelessness using a case study approach. For instance, in a six-year longitudinal study which used a life interview approach, Mayock et al. (2008) identified three major pathways into homelessness: a history of State care, family instability/conflict,

and problematic behaviour along with negative peer associations. They documented that over a half of their sample (n=40) had experienced violence in their homes in early life prior of becoming homeless, while 40% of participants reported parental substance misuse and mental-health problems.

Furthermore, most studies at a national and international level suggest that there is a strikingly high prevalence of early trauma occurring in family environments prior to becoming homeless. Scholars have increasingly commented on the exceptional psychosocial vulnerability of highly marginalised homeless groups and point to the role of childhood adversity when reflecting on causes and triggers of homelessness (Philippott et al., 2007; Maguire et al., 2009; McDonagh, 2011; Fitzpatrick et al., 2013; see also Theodorou & Johnsen, 2018). In a recent statistical analysis in the UK of pathways into MEH, a number of childhood variables were further tested and validated (Fitzpatrick et al., 2013). According to this seminal study, exposure to childhood adversity was widely reported and identified as a key predictor of deep social exclusion. Similarly, a recent report profiling experiences of severe and multiple disadvantage in England indicated that only a small minority of individuals affected did not report any traumatic experiences in their early years (Bramley et al., 2015).

Those traumatic events in early life could possibly account for the poor outcomes and inability to cope in later life among homeless individuals (Maguire et al., 2009). For instance, substantial evidence deriving from homeless and trauma literature demonstrate that early life adversity is highly associated with poor mental health and increased substance misuse in later life (see Fischer & Breakey, 1991; Buhrich et al., 2000, 2003; Kamieniecki, 2001; Goering et al., 2002; Randall, Britten & Craig, 2007; Rees, 2009). Although drawing likely casual inferences amongst the above variables creates a strong argument for the role of trauma in the development of homelessness, the question remains on what it is about trauma that can lead to homelessness in certain circumstances? The next sections will discuss current findings regarding the consequences of those early traumatic experiences for enabling homelessness to occur and attempt to identify overriding mechanisms that link childhood abuse to further victimization.

2.4 Complex Trauma and MEH

In the context of multiple exclusion, the high levels and lasting effects of prolonged and repetitive trauma on psychological well-being is well-recognised (see Ryan 2000; Courtois, 2008; Keeshin, 2011; Roos, 2013). However, a certain ambiguity does exist in evidence-based research in that trauma is examined either as a contributing factor to

experiences of homelessness, or as a consequence of it. Additionally, conceptions of trauma are not always well-defined in literature, often not differentiating trauma as a single event (named Type I) and trauma as the experience of multiple, prolonged, repetitive traumatic events, usually occurring in developmental years (named Type II). Nevertheless, there is strong evidence associating homelessness with experiences of complex and prolonged trauma (such as neglect or abuse in childhood), raising the question whether multiple forms of social exclusion in later life could be also traced to Adverse Childhood Experiences (ACEs).

Herman (1992) introduced the term 'complex trauma' which refers to the psychological harm 'arising from repeated and sustained trauma' that results to a constellation of interpersonal disturbances, with the most prominent being posttraumatic stress disorder (PTSD). She stated that an event becomes traumatic when it threatens one's life and interferes with the neurobiological system for regulating distress. Those adverse experiences tend to leave the person feeling helpless, powerless, unsafe and out of control, and can have significant effects on physical, mental and spiritual development (Courtois, 2008). In the Diagnostic and Statistical Manual of Mental Health Disorders(DSM-III) complex trauma is termed as 'Extreme Stress, Not Otherwise Specified' (DESNOS), associated with a history of interpersonal victimization (Herman, 1995; van der Kolk et al., 1996). Clinical presentations of those individuals differ in the complexity and persistence of psychological and behavioural problems in later adulthood. Those refer to emotional regulation difficulties, impulsive behaviours, distorted sense of self, difficulties in relations with others, psychosomatic and mental health symptomatology and dissociative processes (Hodas, 2006; Cloitre et al., 2009; Dorahy et al., 2009; Dube et al., 2001).

In homeless populations, experiences of complex trauma have been found to be particularly common (Maguire et al., 2009). As previously discussed, researchers conceptualise early traumatic experiences as risk factors for homelessness (Fitzpatrick et al., 2013), or a common experience once homeless (Goodman, 1991; Martin et al., 2006). The event of becoming homeless and sustaining those conditions of homelessness for periods of time can be particularly psychologically traumatising for the individual and could indeed be the trauma itself (see Goodman, 1991). To capture the co-morbidity of multiple forms and types of trauma amongst homeless people, the notion of *poly-victimization* has been applied (Wong, 2016). Wong's study demonstrated that emotional abuse and neglect were prevalent forms of trauma among a large sample (N=389) of homeless youth (71%). It was further suggested that in homeless youth samples, a higher

vulnerability to trauma (i.e. victimization) and early onset of homelessness were evidenced (see also Taylor et al., 2006; Johnsen et al., 2009).

The above findings were validated by a number of studies reporting similar rates (64-90%) of trauma amongst homeless and MEH populations (see Roos et al., 2013; Bramley at al., 2015). In the UK, a recent statistical study on severe and multiple disadvantage has shed more light on key manifestations of trauma within MEH populations. According to Bramley et al. (2015), complex trauma and in particular childhood abuse and neglect were a common experience, affecting about 85% of the studied population, this being individuals with experiences of homelessness, substance misuse and involvement with the criminal justice system. Only a very small minority, 15%, did not report any traumatic experiences in early years (see Bramley et al., 2015). Numerous other studies exploring the impact of multiple traumatic events on the pathways into homelessness produced similar results (see Martjin et al., 2005; Thompson, 2005; Taylor & Sharpe, 2008; Bender et al., 2010; Fitzpatrick et al., 2013).

In detail, the first systematic review that explored the prevalence of childhood physical and sexual abuse among homeless individuals identified high prevalence rates for homeless samples when compared to the general population (Sundin et al., 2015). The rates of experience of childhood physical abuse for homeless populations where estimated to be at 37%, compared to general populations rates of between 4% and 16% (Sundin et al., 2015). In parallel, the rates of experience of childhood sexual abuse where estimated to be at 32% for homeless females and 10% for males compared to 7.5% of all those in the general population (10% for females, 5% for males). Sexual abuse was found to be higher among homeless women, while being a victim of physical assault was more likely to be reported by men (Sundin et al., 2015).

Additionally, based on a growing body of research, age of first experience of homelessness has been identified as being strongly associated with higher levels of experiences of physical/emotional abuse and neglect (Kim et al., 2009; Mar et al., 2014). For instance, Mar et al. (2014) suggested that having experience of a number of ACEs significantly increases the possibilities of first episode of homelessness occurring quite early in life (before or shortly after the age of 16). It was then hypothesised that those who become homeless at later stages may differ in their aetiology of homelessness altogether (Mar et al., 2014).

Some studies have also looked into the type of childhood maltreatment and its particular effects on the individual, as another contributing factor to the onset of homelessness. Active forms of adversity such as sexual and physical abuse have been

predominantly studied, indicating that physical abuse is a significant risk factor for youth homelessness (Ryan et al., 2000). Findings from Ryan et al.'s study (2000) on the psychological consequences of child maltreatment in homeless adolescents revealed significant differences in severity of symptomatology and risk of revictimization among homeless people when active forms of abuse were reported. Other forms of trauma such as emotional and physical neglect have received the least scientific attention, while more recent findings indicated a strong correlation between those variables and homelessness (Mar et al., 2014). A reason for this gap in research might be the high comorbidity of most types of childhood trauma, as well as the increasing numbers of homeless individuals reporting more than one ACE (see Fitzpatrick et al., 2013; Bramley et al., 2015).

Following this, it is worth noting that when exploring the association between psychopathology and ACEs in homeless samples certain limitations do exist. To date, researchers have investigated the impact of ACEs in purposively selected homeless samples (predominantly women and homeless youth) that have previously reported forms of childhood adversity (see for example; Stein et al., 2002; Zlotnick et al., 2007; Tyler et al., 2008; Torchalla et al., 2012; Lim et al., 2015). In this vein, homeless men are often overlooked despite that current statistical findings demonstrate that homeless population which tends to uses low threshold services in UK tends to be dominated by men with complex support needs (Fitzpatrick & Stephens 2007; Philippottt et al., 2007; Fitzpatrick et al., 2011). Furthermore, some heterogeneity exists in how ACEs are defined within each study. Some studies use measures that may include for instance the loss of a parent, or cases of poverty and deprivation, when others do not; while yet others may emphasize the frequency, time and duration of certain types of adversity.

Furthermore, the majority of studies have used questionnaires which rely on self-report, thus a risk to recall bias when referring to childhood experiences may be present. Most importantly though, it is worth bearing in mind that ACE scores are primarily showing probability and they should not be taken as evidencing deterministic and direct causal relationships. To date, the purpose of the majority of existing studies has been to 'diagnose' or identify the existing risks of ACEs, rather that explore the role of early trauma in the lives of participants. In this vein, avoiding decontextualizing ACEs from an individual or group's wider socioeconomic background has been a critical limitation for a number of studies.

Overall, the commonality of trauma in homeless populations makes it hard to infer any distinct differences in individual pathways between those that may have traumatic experiences prior to becoming homeless and those with adverse life events once homeless

(Martin et al., 2006). A reason for this might be that homeless individuals that experience certain types of childhood maltreatment in early and adolescence years often experience multiple forms of additional trauma as they grow older (Ferguson, 2009). Martjin and Sharpe (2005) suggested that more research is needed to investigate whether traumatic experiences and related disorders are a cause and/or a symptom of homelessness. Nonetheless, research is clear that early trauma enhances vulnerability to environmental challenges, increases the risk for retraumatization and consequently heightens the chances for creating a pathway into homelessness (Ryan et al., 2000; Roos, 2013; Sundin, 2015; Edalati et al., 2016).

2.4.1 The effects of complex trauma

As noted above, research has increasingly drawn attention to an overrepresentation of early trauma amongst homeless populations; so too significant correlations between ACE and the risk of homelessness. Broadly, ACE studies report that those risks are proportionally increasing when higher levels of childhood adversity are reported, while in turns those experiences increase the likelihood of poor mental and physical health in adulthood (Ryan et al., 2000; Keeshin et al., 2011; Montgomery et al., 2013; Sundin et al., 2015). The relationship between mental health disorders, physical symptoms and childhood trauma is further evident from a series of well-designed ACE studies (for a comprehensive review see Felliti, 1998; 2006; Anda et al., 2006; Bellis, 2013; Hughes et al., 2017).

Prolonged and repeated forms of trauma when occurring in childhood have been associated with the development of psychopathology, problematic attachment to others, personality disorders (PD), higher suicide rates and substance misuse (Stefanidis et al., 1992; Ryan et al., 2000; Christensen, 2005; Kim, 2010; Merrill et al., 2011; Roos, 2013; Ratelade et al., 2014; Keane et al., 2015). That is not to say that all individuals with experience of early trauma will necessarily develop some form of psychological disorder, will be involved in health harming behaviours in later life, or find themselves homeless. However, the poor socio-cultural conditions when combined with distressing experiences such as witnessing domestic violence, parental separation and/or parental substance abuse and poor mental-health amplify the impact of early trauma and enhance the possibilities for re-victimization (Edalati, 2016).

In this light, evidence from research conducted in the UK argues that the more acute the socio-demographic circumstances of a family, the greater the likelihood (and severity) of its members experiencing multiple ACEs (see Bywaters et al., 2016 for a full review).

Bywaters et al. (2016) highlighted a strong association between family poverty and an increased prevalence of child abuse and neglect. The relationship was attributed either to the direct impact of lacking material goods, or to parental stress and poor physical environment (e.g. living in a deprived area). The association between childhood deprivation of various forms (e.g. not having enough to eat at home) and trauma in early life has also been highlighted as a strong predictor of extreme exclusion. On this subject, Fitzpatrick et al.'s (2013) study of MEH evidenced a causal relationship between childhood adversity and poor mental health outcomes and further suggested that those negative outcomes typically occur early in pathways into homelessness.

Evidently, high rates of mental health difficulties (often undiagnosed) have consistently been reported among homeless and social excluded individuals compared to general populations (Fazel, Khosia, Doll et al., 2008; Maguire et al., 2009; Rees, 2009). Rates affect 50%-80% of the homeless population, with depression and anxiety being particularly common **(**Bahrich et al., 2000; Fazel et al., 2008; St Mungo's, 2009; Rees, 2009). Posttraumatic stress disorder (PTSD) has also received some attention, although findings remain unclear due to the fact that PTSD has been shown to co-occur with substance misuse difficulties in this population (Tyler et al., 2003; Stewart et al., 2004; Thompson et al., 2006; Rhoades et al., 2011).

Additionally, a few studies have systematically diagnosed the full range of AXIS I (Personality Disorders) and II (mental health and substance misuse) in deprived populations. In particular, clinical assessments indicated that estimated rates of personality disorders among homeless populations are comparable to psychiatric populations, varying between 40% and 70% **(**Tolomiczenko et al., 2000; Ball et al., 2005; Fazel et al., 2008; Maguire et al., 2009). Those findings, amongst others, highlight the need for targeted intervention and psychologically-minded approaches when addressing the needs of highly excluded populations.

Evidently, as Koegal et al. (1995, p. 1647) noted, the dynamics that emerge between ACEs and moderating factors have the potential to *"shape and constrain the intra and interpersonal resources that children can draw from as adults"*. The question that emerges is in what ways those early traumatic experiences compromise or otherwise influence the abilities of homeless individuals to engage with support? In this vein, Scanlon and Adlam (2006) introduced the term 'unhoused minds' to illustrate how homelessness relates to internal states of mind rather than solely to the lack of housing. That is to say that when part of one's early life experiences were not necessarily in a stable and secure home, when offered one this can be a frightening and difficult experience to manage (Cockersell, 2011).

They further assert that the concept of 'chaotic' behaviour which is often described as a characteristic of this population is *"a mirroring of the divided experience of clients' fractured experiences of themselves"* (Scanlon & Adlam, 2012, p. 78). Following from this, one may surmise that the ambivalence and incoherence of the engaging patterns of MEH populations are not only understandable but also somewhat unsurprising.

2.4.2 Psychological perspectives

The association between childhood adversity and becoming or maintaining homeless has been a focus of fascination in literature, particularly that written from a psychosocial perspective. Some prominent examples are the risk amplification model, learned helplessness theory and the theory of choice and exchange. Those theories attempt to explain how childhood maltreatment and interfamilial constraints increase the risk of homelessness occurring, whilst exploring the underlying psychological factors as predispositions to chronic homelessness.

In explaining the overriding mechanisms that link childhood abuse to further victimization and homelessness, the risk amplification model portrays how young individuals coming from dysfunctional and troubled homes may develop a greater risk for becoming homeless (Whitbeck et al., 1999). Within this model, drug use and further traumatization on the streets are seen as symptoms of early cumulative trauma and a lack of appropriate support (Whitbeck et al., 1999). In particular, abusive environments, but also inadequate systemic and interfamilial resources, are said to increase the risk for early onset of youth homelessness (Tyler et al., 2001). Researchers suggest that as a response to unprocessed trauma and neglect a set of coping strategies develop that may lead to engagement in risky behaviours, which further exacerbate existing psychological distress (Whitbeck et al., 1999; Tyler et al., 2001). Consequently, when runaway youths reach the streets they tend to associate with 'deviant peers' and engage in 'deviant subsidence strategies' (such as street culture activities and substance misuse). In this respect, the model explains why cumulative trauma has often been found to be a precursor to substance misuse in homeless groups (Stein et al 2002; Tam et al., 2003; Zlotbick et al., 2004;).

The theory of choice and exchange offers an additional perspective. Nye (1980) suggested that choices are taken through comparing rewards and evaluating the costs anticipated for a runaway situation. In runaway situations the cost of staying at home (further childhood maltreatment) exceeds the costs of leaving and acts as a motivator for running away. However, homelessness in itself can be considered a trauma in multiple ways (Goodman, 1991). The loss of home, social roles and connection can be detrimental for the psychological and physical health of the individual (FEANTSA, 2017). In those cases, the construct of *learned helplessness* has been proposed for conceptualising the behavioural manifestations and effects of the trauma in itself (Burn, 1992; Scaglia, 2008). Goodman (1991) suggests that the trauma of homelessness can evoke feelings of helplessness, depression and loss, leading to certain passivity to control daily life. The traumatised individual believes that s/he has no longer control over their current situation

and feels that they 'cannot influence the environment' in any form (Goodman et al., 1991). Scaglia (2008) reports that incidents of chronic homelessness are associated with increased manifestations of *learned helplessness*. This is not surprising, if we consider the high prevalence of depression and suicide rates among individuals that are chronically homeless (Stein et al., 2002).

The indirect impact of ACE and the interplay of psychological, cultural and social processes in amplifying the risk for MEH and revictimization are evident in homelessness literature. However, not all individuals that experience complex trauma are necessarily going to develop mental health disorders, misuse substances and/or experience of MEH. Early intervention, family support and the buffering effect of close and supportive relationships significantly decrease the risk of leaving home (Tyler et al., 2008). Indeed, trauma theory postulates that attachments to others and strong support networks can determine the nature and extent of one's reaction to trauma. In that sense, having supportive relationships is not solely important when looking at risk factors for those who become homeless, but also when looking for solutions. However, it is not always clear whether policy and practice responses towards homeless individuals are taking into consideration the relational and behavioural processes of the very population they are targeting.

2.5 Policy and practice responses to MEH

The increasing recognition of the prominence of complex trauma in the life histories of people experiencing MEH has meant that there is a call for better service responses (Cornes et al., 2014; Bramley et al., 2015). The high degree of intersection of a number of difficulties in this deeply socially excluded group generate a number of questions as to how support might be delivered most effectively. Responding to this need, a growing interest has been noted by scholars and policy makers in developing new ways of thinking about and tackling MEH. This section will explore the current state of knowledge and the practice responses in addressing the psychological and emotional needs of people experiencing MEH. As noted, existing research suggests that the pervasiveness of traumatic stress and its long lasting effects severely affect interpersonal relationships, behaviour and coping strategies, and consequently an individual's relationship with care and support (Keats et al., 2012).

At a national level, tacking homelessness and multiple exclusion has been high on the agenda of UK governments (see Fitzpatrick et al., 2017, 2018, 2019; Bramley., 2017, 2019). As a response to the DLGC (2009) guidelines for personalised responses to rough

sleeping and entrenched homelessness, a number of evaluation reports were published (Pleace, 2008; DCLG, 2011; Homeless Link, 2013). Those primarily suggest that agency responses should aim to be fast and appropriate to the needs of those at risk of homelessness, while the support for exiting homelessness should be accessible and pro-active (DCLG, 2011, 2012). However, a set of barriers in meeting the presenting support needs of people experiencing MEH were noted in a number of papers (MEAM, 2009; Watson, 2010; Cornes et al., 2011,2014).

Cornes et al. (2014) reports that services often prove unable to support those individuals in a coordinated fashion as responses tend to be fragmented. Professionals are reported to regard multiply excluded individuals as hard to reach and engage, resulting in needs being frequently addressed in isolation of others (MEAM, 2009). The use of a number of 'professional lenses' to address their multiple needs (for instance addiction services or mental health services) instead of creative and holistic approaches, unavoidably led to those individuals 'falling between the gaps' of support (Fitzpatrick et al., 2011). The absence of coherent responses in combination with the multimorbidity of needs associated with MEH often led to a phenomenon called the 'revolving door' (Cornes et al., 2011) wherein individuals access several services repeatedly, yet none of them responds effectively to the presenting issues.

In this vein, Rosengard (2007) noted that the *inverse care law* can be said to apply to homelessness, in that individuals presenting with the greatest complexity of issues are often excluded from services when they need them most. Dual diagnosis has proven to be a particular challenge for social and housing workers (Kvaternic et al., 2009; Hennessy et al., 2013), given that an individual with a drug addiction and severe mental health problems may be rejected by both an addiction and a mental health service concurrently (Hennessy et al., 2013; Lawrence-Jones, 2010). Professionals within these services tend not to agree about which 'problem' needs to be addressed first, whilst there is a profound lack of services equipped to address both. In all, *"the more complex a person's needs, the more likely they are to fall through the gaps in services society provides"* (Rankin, 2004, p. 11).

Recently, a few studies have also identified barriers in current practices and policies in developing effective ways of working with people experiencing MEH (Cornes et al., 2013; Hennessy et al., 2013; Cornes et al., 2014; Manthorpe et al., 2013; Shelter, 2016). Among others, dispersed and fragmented communication among services, stigmatization, not treating service users with respect, and procedures being solely 'driven by' assessment were some aspects that were widely reported (Drabyshire, 2006; Martins, 2008; Pedgat et al., 2008). Similarly, in Rosengard's (2007) systematic review in the UK, access

difficulties and ineffective contact including poor awareness of appropriate referral services were widely reported by service users with complex needs. Although some valued aspects of service provision have also been noted in literature, the argument that individuals experiencing MEH are often poorly served by services prevails. In this light, Anderson (2011, p. 28) writes:

> "…adults with multiple needs often brush contact with a wide range of services across health, welfare and criminal justice. Too often they will be 'famous faces' for all the wrong reasons. They will fail to engage, fail to make progress and be a source of considerable frustration for professionals. They will also be costly to the system, accessing expensive crisis services rather than structured support".

These issues highlight the need for a broader vision that acknowledges the nature of complexity in individuals' lives and moves beyond standard and inflexible approaches. A range of commentators call for more holistic and sophisticated approaches where priority lies in addressing the reasons behind disengagement, failure to engage, and transition off the streets (Cabinet office, 2007; Clinks et al., 2009; Fitzpatrick et al., 2011). As an alternative to the high levels of repeat homelessness and the reported 'resistance' of this complex group to engage with support in a constructive way, a number of housing-related support services piloted the *Housing First* approach (for a full review on the efficacy of the Housing First model in the UK see Johnsen & Teixeira, 2010, 2012; Johnsen et al., 2013).

This philosophy is based on directly placing the most vulnerable individuals (from shelters, or straight from the streets) into permanent accommodation with long-term tailored and intensive support. Once accommodation is stabilised, it then provides the basis for other changes to occur (Tsemberis, 2010). This model supports the development of long term supportive relationships and so called 'soft' outcomes (Shelter, 2016). Padgett et al. (2008) argues that Housing First approaches predominantly work with individuals that are not 'conforming' to more 'restrictive environments', indicating that better outcomes are closely linked with flexibility and sensitivity across practices. In support of this notion, housing support within this model is provided in a relatively 'unconditional' and flexible way, and its intensity is determined on a client-centred basis (Johnsen, 2013; Cabinet office, 2010).

Other models aiming to provide appropriate and individualised support include Psychologically Informed Environments (PIE) and Trauma Informed Care (TIC). Those frameworks have been proposed as plausible means of redressing the lack of psychological thinking in service delivery (Hopper et al., 2010; Keats et al., 2012). The pervasiveness

and persistency of various psychological and emotional needs in MEH populations require a philosophical and cultural shift within a whole service (Hopper et al., 2010). In this respect, the PIE approach *"...is one that takes into account the psychological makeup – the thinking, emotions, personalities and past experience - of its participants in the way that it operates"* (Johnson, 2012, p. 2). This may include changes in the physical and social spaces, training and provision of adequate support for staff and service providers, and valuing softer outcomes (Keats et al., 2012).

PIEs have influenced current efforts in addressing the psychological and emotional needs of those experiencing complex trauma and in promoting recovery (Johnson et al., 2011). Recent reports suggest that PIEs should be applied within services for limiting exclusion incidents (Seager, 2011; Keats et al., 2012; Bramley et al., 2015). Considering that the interaction of services with users who have histories of complex trauma are often problematic and unproductive, a psychologically minded approach seems to be key (Johnson and Haigh, 2012; Keats et al., 2012). Central interpersonal challenges (often interlinked with previous experiences of trauma) are identified and worked through within such an approach. This can result in the increase of engagement levels, whilst exclusion incidents may be diminished (Shelter, 2015). As Adshead (2001, p. 328) contends: *"So often we see people who are longing for a secure attachment that would reduce their distress, but have no idea either how to elicit care productively, or how to use it when it is offered by a competent caregiver"*.

Similarly, the TIC framework places the psychological needs and well-being of the individual at its centre. Hopper et al. (2010, p. 82) defines it as *"a strength-based framework that is grounded in an understanding of and responsiveness to the impact of trauma"*. Evidence suggests that effective application of the approach results in better collaboration between services and improved emotional reactions of participants to services, while service users often report an increased sense of safety when the approach is applied (Community Connections, 2002; Moses et al., 2003; Morrissey et al., 2005; Cocozza et al., 2005; Christensen et al., 2005). In that sense, both the TIC and PIE concepts aim to use positive ways of managing relationships without *"re-enforcing the client's sense of rejection and abandonment"* (DCLG, 2015, p. 6).

To date, there are only a handful of published reports that give insight into the effectiveness of PIEs in the homeless sector (Cockersell, 2011; Stronge & Williamson, 2014; Cockersell, 2016). In one study, Stronge and Willamson (2014) concluded that this approach has been particularly useful for homeless individuals that may be deemed 'hard to reach'. In particular they reported higher levels of engagement and improved mental

health outcomes amongst service users. Similar findings were also reported by Cockersell (2011) which aimed to explore whether chronically excluded individuals were excluded because of their psychological difficulties. However, both the above studies used a psychotherapeutic intervention as part of the programme, making it hard to determine to what extent outcomes were due to other elements of the PIEs or due the specific therapeutic intervention applied.

The single attempt to review practice-based evidence and looked at the range of data from evaluations of current PIE services in UK and Ireland was recently conducted by Cockersell (2016). Data derived from a range of sources: self-evaluations, external evaluations and organisation-specific measures over short and longer periods of time. The review reported better housing outcomes, improved mental health, and reduced social exclusion for homeless people, together with better staff morale and interactions amongst staff members. To date, the most cited effects of PIEs refer to higher engagement levels for clients that have experienced multiple deprivation and an increased ability to accept care and make use of the support offered (Cockersell, 2016). Key to this is the concept of *elastic tolerance* which encourages flexible and creative ways of responding and dealing with issues which normally result in warnings or evictions (DCLG, 2015, p. 6).

To date, evidence shows that PIEs are promising in the way they set out to acknowledge the emotional trauma and its long lasting effect on an individual. However, there is no clear prescription regarding how the approaches should be implemented and services may apply them as they please. One reason for this might be that their development is not, as yet at least, officially underpinned by a specific school of thought (Johnson & Haig, 2011). That said, most services that implement a PIE framework are using psychodynamic frameworks supported by trained psychotherapists or psychologists (Cockersell, 2011; Williamson et al., 2014). This is not surprising considering that PIEs appear to be most effective when based on an in-depth understanding of the interpersonal dynamics of trauma and styles of engagement.

The volume of evidence regarding TICs is also limited. To date, findings on the effectiveness of TIC derive predominantly from the mental health and addiction fields. However, the few existing reports within the homeless field indicate some positive outcomes. In detail, upon implementation of the TIC approach, positive effect on housing stability (Rog, 1995; Kammerer, 2013) and a decrease in the use of crisis based services (Community Connections, 2002) have been noted. In a large multisite study, Morrissey et al. (2005) argued that the integration of services that are trauma informed can be particularly beneficial for individuals with histories of trauma and comorbid disorders. The

study used a control group of women with co-occuring disorders (n=2,026) of whom 70.4% had experience of homelessness. Results indicated that the women who received trauma specific interventions exhibited significant improvements in mental health and substance misuse outcomes.

Evidently, the interpersonal factors faced by service users (often interplaying in their relationships with staff members) require adequate responses, considering that in most cases voluntary and crisis services remain the main contact points over prolonged periods of time for a number of individuals with histories of complex trauma. Although still in their infancy, findings from PIE and TIC interventions in the field of homelessness seem promising. However, more research is required to explore their effectiveness with MEH individuals. A fundamental challenge is to prepare services to enable better engagement practices that are not linear, but rather embrace the complexity and 'chaos' that service users may display in their day to day presentations. In this vein, a number of reports indicate that it is not uncommon for professionals to feel 'out of their depth' in their attempt to create positive relationships with 'hard to reach' individuals (Scanlon & Adam, 2011; Cornes et al., 2014).

Overall, commentators suggest that there is a pervasive need for developing multidisciplinary and integrative approaches where agencies in housing, health, criminal justice and social care sectors collaborate in developing a holistic framework for tackling MEH (Cornes, 2014; Breedvelt, 2016). However, on a service level, there is still a lack of knowledge in developing effective actions when supporting MEH populations (Cornes et al., 2014; Bramley et al., 2015; Breedvelt, 2016). Literature now acknowledges that *"these people are probably the most emotionally damaged group in society… and have the most damaged or disrupted developmental backgrounds of abuse, trauma, neglect and broken attachments"* (Seager, 2011, p. 186). In an attempt to rethink the design and routine practices of homeless services, psychosocially-minded approaches have been proposed. At the forefront of those practices is developing trusting relationships by having an open and flexible approach towards challenging behaviours and missed appointments, training staff to deal with difficult behaviours, and measuring softer outcomes when assessing 'distance travelled' (Shelter, 2016).

Conclusion

This chapter has looked into the general definitions of homelessness, its causes and risk factors, and paid particular attention to the more extreme manifestations of homelessness. It also discussed the effects of trauma on those experiencing MEH and reviewed current practice responses with those that are often labelled as 'service resistant'

or ‘difficult to engage’. The overlap of issues experienced by those at the sharp end of society have been evident across literature. Findings suggested that there is a higher prevalence of cumulative trauma and psychological vulnerability in multiply excluded populations than is true of the homeless population (or indeed wider population) more generally (Pleace et al., 2008; Fitzpatrick et al., 2013). This evidence may partly explain why those individuals are further challenged by their psychosocial difficulties, while their relational skills are somewhat impaired. As also noted the experience of homelessness and social exclusion is further exacerbated by the lack of adequate support systems, funding and support (Gaetz et al., 2014).

Considerable difficulties have been noted by service providers in engaging and establishing effective and positive relationships that can foster recovery with this particular population. Literature suggests that mainstream services typically fail to implement a comprehensive and co-ordinated approach to meet the complexity of presenting needs. The lack of effective contact with services exacerbates current difficulties, leads to further marginalisation, and generates higher costs for society (Clinks et al., 2009; MEAM, 2009). A question that arises here is what is it about current interactions with services that is so ‘problematic’? Further to this, what are the difficulties and barriers that service staff on the one hand and service users on the other face when attempting to resolve instances of MEH?

This study seeks to contribute to this endeavour by employing an attachment based approach. It is proposed that this relational approach can form the basis for new insights into the current relating patterns of MEH populations, whilst it can inform practice approaches in a number of constructive ways. In particular, it is argued that attachment theory is a key theoretical approach for understanding the often perplexing behaviours of people with experience of MEH and the interpersonal dynamics of trauma. Although the transformational nature of relationships is well established in literature, what actually this may entail when MEH populations are concerned is yet to be explored (Balda, 2016). Within the next chapter, an overview of the paradigm of attachment and its relevance to homeless populations will be provided.

CHAPTER 3: Attachment Theory, Relational Styles and Responses to Adversity

Introduction

In order to gain an understanding of the attachment experiences and attachment needs of MEH populations, this chapter provides an overview of attachment theory and attachment styles, explores current research findings of attachment and homelessness, and discusses the link between insecure attachments and trauma. It consists of four sections: the first provides a historical overview of the development of attachment theory and adult attachment styles. The next discusses a model of attachment functioning in the regulation of emotions and attempts to integrate trauma theory with attachment literature. It also provides a review of research findings associating attachment predispositions with mental health difficulties. The chapter then goes on to review current research on attachment and homelessness, while the final section looks into potential applications of the attachment framework for establishing and maintaining supportive relationships with MEH populations.

3.1 The Development of Attachment Theory

Attachment theory is an integrative and evidence-based framework which aims to provide a comprehensive understanding of interpersonal functioning. It has been previously described as "*one of the most solidly founded theories of human psychology"* (Brisch & Kronenberg, 2012, p. 14). The significance of relationships and their ongoing impact on functioning was originally theorised by Bowlby in the late 1960s. Bowlby (1969) proposed that there is an instinctual disposition in the individual for proximity, in both physical and emotional senses, to prime care givers in pursuance of survival. Such a disposition is founded upon a behavioural system that constitutes the key elements of the theory. Those behaviours are driven by: (1) the need for comfort and emotional regulation in times of threat that could be provided by attachment figures; and (2) the expression of distress and anxiety in cases of prolonged separation or unresponsiveness from those figures (Hazan & Diamon, 2000). Attachment theory is primarily a social based model, in that an individual seeks support from others (even if this is in a symbolic way) for regulating their emotions and minimizing the impact of distress (Sroufe, 2005; Coan, 2008).

The theory is based upon a two-dimensional model which distinguishes between a

secure and insecure attachment which is developed in early stages with a care figure. The observed interactions in early life are often referred to as attachment styles and were initially described in terms of three categories; (1) secure, (2) avoidant and (3) anxious-ambivalent (Ainsworth & Bell, 1970[1]). Since then substantial empirical research has been conducted and those three attachment styles have been revised and reformulated (Hazan & Shaver, 1987; Bartholomew & Horrowitz, 1991). Theorists have since developed a fourth category referred to as disorganised/disoriented that has been associated with cumulative experiences of trauma during early years (see Main & Solomon, 1991). A review of those attachment styles and changes in their conceptualisation over time will be elaborated within the next section of this chapter.

The mechanisms of the theory are based on the idea that early experiences formulate Internal Working Models (IWMs) which later elicit certain behaviours within relationships (Collins & Allard, 2004; Berry, Barrowclough & Warden, 2007). Those models refer to mental representations of the self, significant others, and expectations and beliefs about the world (Hazan & Shaver, 1987). These are deemed as integral for gaining an insight into how psychopathology could develop (Bowlby, 1988; Bretherton & Munholland, 1999). Fraley (2002) suggested that those representations provide the foundation for creating a 'prototype-relationship' that the person will replicate in later relationships. Others argue that those representations form the basis of behaviour and emotion regulation throughout the lifespan (Gutterman-Steinmetz & Crowell, 2006).

In its earliest formulation, attachment theory was primarily focused on early life experiences, emphasizing the parent-child relationship in particular. It explains that in *secure* attachments, the availability and responsiveness of the attachment figure (usually the mother) allows the child to develop an internal sense of safety and trust (Karen, 1998). In such circumstances, the parent acts as a secure base for the infant to develop socially, psychologically and physiologically. When no major disruptions in this attachment occur the child will develop positive IWMs (Ainsworth et al., 1978). Those positive models are translated into a positive image of self as worthy of attachment and the image of others as available to meet those attachment needs. Subsequently, this will lead to the development of constructive responses when dealing with stress and it will allow the person to attend to

[1]Mary Ainsworth collaborated with John Bowlby in producing a joint publication (Child, Care and Birth of Love, 1965) and further elaborated the Attachment Theory by developing a procedure for establishing the attachment styles between a mother and a child. The 'Strange Situation' experiment refers to the assessment of the quality of attachment relationships in early life through structured observational research (Ainsworth et al., 1978). Based on the presenting behaviour during two episodes of separation and reunion with the prime caregiver children are classified into three categories: secure, avoidant and ambivalent.

emotional regulation strategies and social support as and when needed (Mikulincer & Shaver, 2007).

In contrast, the experience of negative emotions within this affectional bond that derives from inconsistency, neglect, and unavailability of the parent in times of need leads to reduced ability to regulate this anxiety. In these *insecure* attachments the need to modulate difficult emotions through support seeking behaviours remains unmet, thus negative IWMs are developed. Insecure attachments are characterised by a low sense of self-worth. Consequently, insecure individuals exhibit distrust in the responsiveness and availability of others and have negative expectations when seeking support. For instance, individuals with secure attachments may easily engage in help-seeking behaviours when in distress, whereas individuals with avoidant attachment styles are highly likely to avoid attending to any kind of support (Mikulincer & Shaver, 2007).

3.1.1 Understanding Adult Attachment

Attachment theory is one of the most elaborated models of psychological functioning in early but also in later life. Coming from a number of perspectives, theorists and researchers have argued that attachment experience in childhood interlinks with attachment style in adulthood (Mikulincer & Shaver, 2007). This assertion is closely linked with a longstanding debate about whether attachment patterns are stable from infancy to adulthood or are modified through experiences over time (see Fraley, 2002 for the debate). On one side of the debate, known as the *revisionist* perspective, researchers hypothesize that attachment styles may be subject to change (i.e. can be strengthened). It is plausible that some individuals may move from having insecure to secure attachments when relational issues are openly addressed, for example (Siegel, 1999; Schore, 2003). According to this approach, attachment patterns are open to environmental influences, thus early patterns may or may not necessarily correspond to those developed in later life (Kagan, 1987). On the other side of the debate, the *prototype* perspective suggests that attachment styles are not subject to change throughout development and the ones formed in early life have a continuous effect throughout life (Sroufe et al., 1990; Owens et al., 1995).

It has also been suggested that in adulthood individuals develop different working models for different relationships to meet their attachment needs (Collins & Read, 1994; Mikulincer & Shaver, 2007). In fact, one may have multiple working models based on the number of strong attachments that have formed (Collins & Read, 1994). This 'hierarchy of attachment figures' (Bowlby, 1982) is based on the strength of the emotional ties that

develop with each person and the needs they are meant to fulfil. Those may include support figures, romantic partners, friends and important others. Following a prototype perspective, Mikulincer and Shaver (2007) suggested that despite the fact that those attachments concern different relationships, they are all organised under a single working model, or put another way, the general characteristics of the working models in early life are replicated in other relating patterns. A critical limitation of this concept is that those working models are only examined and identified during the early years within the mother-child relationship. In that sense the theory very much prioritises the relationship with the prime caregiver, thus attachments to other important and potentially influential figures may be often neglected.

Despite those debates, what is rather consistent across perspectives is the idea that when looking into early attachments and working models of self and others there is a great capacity to inform and on occasion predict social adaptation and vulnerability. A substantial body of studies deriving primarily from the developmental and social psychology tradition has explored the link between early attachment and adaptation in later adulthood. Both approaches are based on the same hypothesis, this being that anxious and avoidant attachments in early childhood are associated with vulnerability to psychopathology and a lack of constructive strategies for positive adaptation in later adulthood (Sroufe et al., 2000; Mikulincer & Shaver, 2007, 2012). Existing research, partly, also suggests that previous insecure forms of interpersonal functioning are replicated in current relationships and account for interpersonal problems (Muris & Meesters, 2002; Shorey & Snyder, 2006; Marganska et al., 2013).

However, insecure attachments are not necessarily indicative of psychopathology, especially when adequate support is offered from other attachment figures. Furthermore, Kagan (1987) argued that while attachment theory presents some powerful ideas on the enduring nature of relationships over the life course, it severely underestimates human capacity to self-repair and self-soothe. He further argues that the concepts of autonomy and self-direction are not given enough attention by attachment theorists who tend to support the notion that self-regulation is mainly, if not solely, attainable through the internalization of relationships with others. Nonetheless, attachment theory is not the only driving force when it comes to self-regulation. Evidently, attachment theorists have not shown enough appreciation to the critical role of other constructs, such as personality traits and cognitive processes (e.g. problem solving or motivation) when it comes to self-repair. Thus, attachment is a crucial developmental construct but it should not be treated as the only one, especially at the expense of other constructs that interplay and affect

development.

All things considered, insecure attachments are perceived to be one of the most salient risk factors for the development of mental health difficulties and cumulative trauma. This is attributed to the fact that high attachment insecurity severely impairs one's ability to access the very things that can ameliorate those effects; these being supportive relationships. In this project, the priority lies in exploring the modifying effect of attachment experiences in relation to MEH individuals' patterns of engagement with support services. It is hypothesised that insecure attachment patterns and emotion regulation strategies act as risk factors for homelessness and also affect individuals' relationships with support. It does not necessarily take a stance in relation to the above debates over the degree of stability of attachment styles over the life course. Furthermore, it does not claim that human connection is the only and/or overriding factor affecting these things. It does however suggest that a better understanding of attachment styles presented by people with experience of MEH may facilitate the development of more efficient and beneficial service approaches for this population. It suggests that current attachment processes can shed light and address the current gaps in recognising the relational difficulties of those individuals when seeking or disengaging from support.

3.1.2 Attachment styles

In adult attachment research, there are two major models for conceptualising attachment. Their difference has been compounded by the use of categorical versus dimensional approaches to the assessment of attachment style. The first paradigm was developed by Hazan and Shaver (1987) in their work on attachment styles in relation to adult romantic relationships. Following Ainsworth's (1978) basic model of attachment, Hazan et al. (1978) translated the initial three attachment styles (secure, avoidant and ambivalent) into adult attachment styles (secure, avoidant and anxious). The model was based on research suggesting that the qualities of attachment relationships in early life are replicated in future intimate relationships. Those qualities include feelings of security, comfort support and a sense of belonging (Freeney, 2004; Collins, Guchard & Freeney, 2006; Mikulincer & Shaver, 2007).

Those were shortly reviewed and revised by a number of researchers who focused on dimensional models of attachment and further explored adult attachment processes (see Collins & Read, 1994; Griffin & Bartholomew, 1994; Brennan & Shaver, 1995). For instance, Brennan et al. (1998) argued that attachment can be also organised within a two-dimensional space, referring to an avoidant and an anxious dimension of attachment (see

Figure 3.1). The anxiety dimension refers to high scores on fear of rejection and worry of abandonment in romantic relationships, and the avoidance dimensions concerns high scores on discomfort with closeness and high self-reliance.

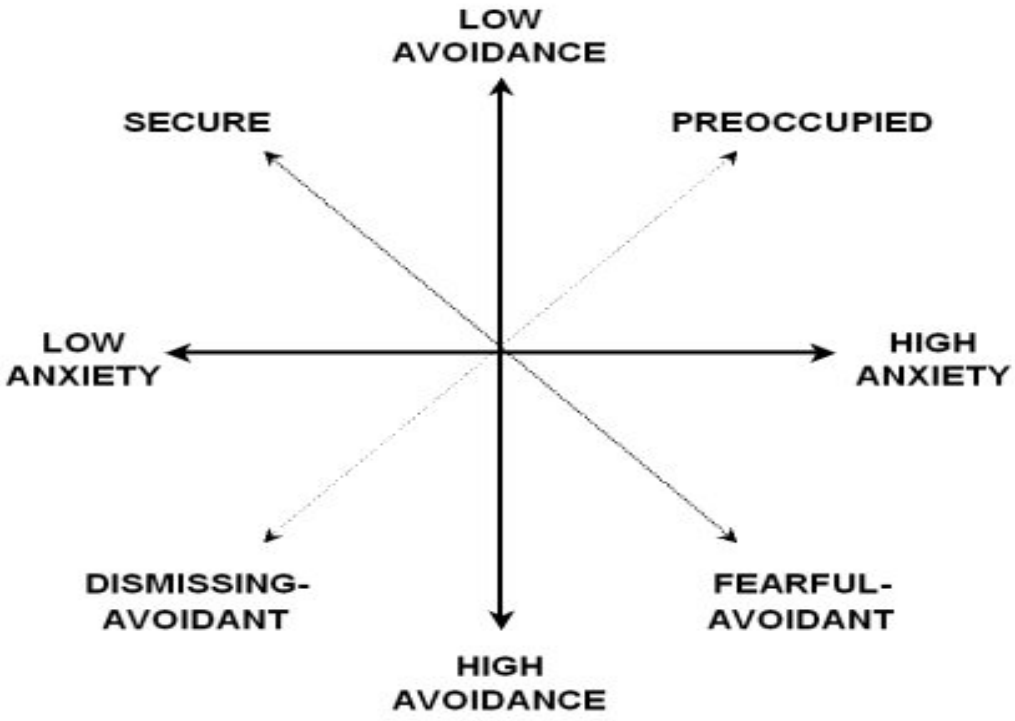

Figure 3.1 Two dimensional four category model of attachment. Secondary source: Fraley et al., (2015), p. 45. (For first publication see Fraley & Waller, 1998)

Bartholomew and Horrowitz (1991) further expanded Hazan et al.'s (1987) initial model by developing a four-category model (wherein the categories included secure, preoccupied, dismissing, and fearful). They argued that these four categories of attachment can also be conceptualised as dimensions either in cognitive terms (as beliefs about self and others), or in affective terms (as anxiety and avoidance) (Cassidy & Shaver, 1999). The four patterns of attachment are based on two underlying axes: the working *model of self* and the working *model of others*. Models of self and others are dichotomised as being either positive or negative (positive/negative view of self and positive/negative view of others). The *model of self* was associated with the idea of self as competent and self-worthy, while the working *model of others* represents the degree to which relationships are perceived as rewarding and necessary (see Figure 3.2). In the exploration of how individuals may use social support in the face of adversity, the differentiation between the idea of self and others is of particular significance.

A number of studies have used the categorical and dimensional models interchangeably and indicated that the four-category model has robust correlations with the two-dimensional model (Sibley et al., 2005). *The model of self* has been conceptualised as meeting the anxiety dimension and *the model of others* as meeting the avoidance dimension (Shaver & Mikulincer, 2002). For instance, secure individuals are associated with low scores in both anxiety and avoidance scales, while those with a fearful pattern exhibit features of both the avoidant and anxious dimensions (see Figure 3.1). In research contexts the investigation of attachment is characterised by the development of a variety of models, interpretations and measures (see Appendix C). Nonetheless, Bartholomew's and Horrowitz's (1991) attachment model is considered to be the most prominent and well-elaborated model and has been extensively studied and used in empirical research. This model covers most aspects (if not all) of attachment theory and it will provide the basis for this study.

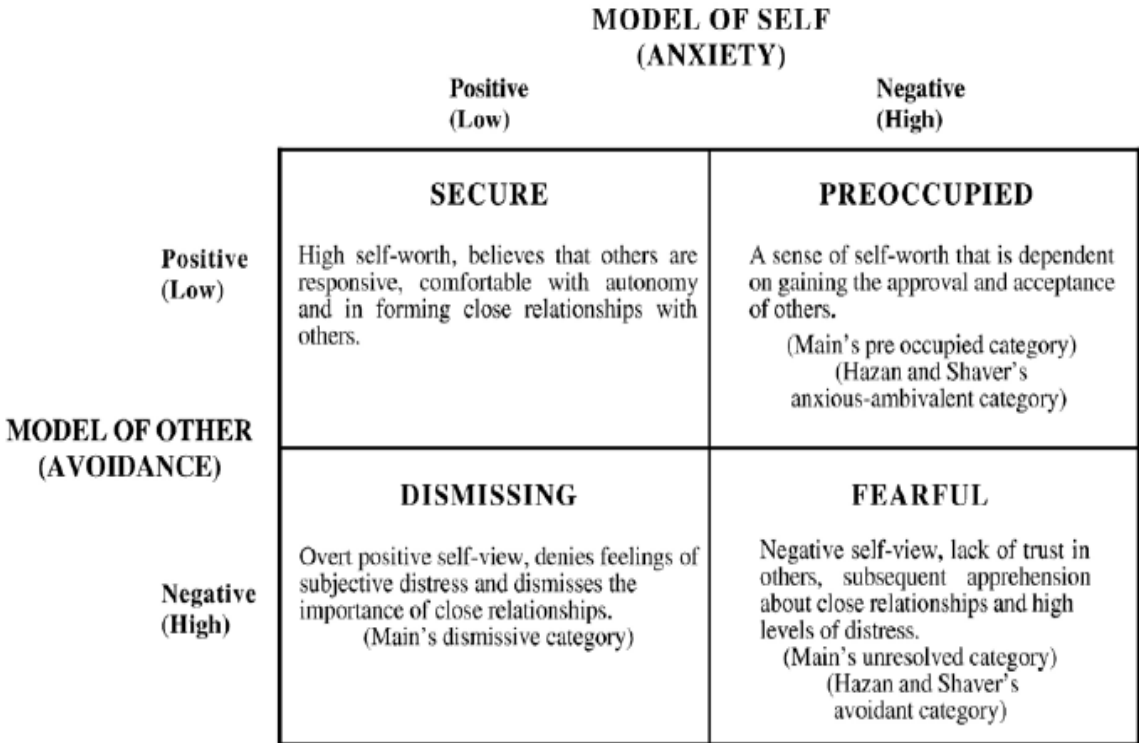

Figure 3.2 Bartholomew's model of attachment (1992). Source: Bartholomew and Horowitz (1991), p. 227.

According to this model, attachment styles are divided into: secure, dismissing, preoccupied and fearful. *Secure* individuals have a positive image of self and others and they tend to view others as trustworthy and supportive. This pattern is related to a felt sense of security and comfort with intimacy and autonomy (Bartholomew, 1991). Driven by their positive perceptions of others, secure individuals are more likely than those exhibiting other attachment styles to seek support when in distress (Mikulincer et al., 1993; Ognibene et al.,

1998).

Dismissively attached individuals have a positive view of self but a negative view of others. Dismissive attachment patterns are characterized by deactivating strategies and behaviours of compulsive self-reliance (Fraley & Shaver, 1997). Engagement with social support remains poor in times of distress. Individuals with dismissive styles tend to distrust others, display defensive attitudes, and use distancing strategies that inevitably lead to high levels of social isolation and hostility (Guerrero, 1996; Collins & Feeney, 2000). This cognitive and emotional suppression of their attachment needs and withdrawal from social interaction has often been associated with mental health deterioration (Ein-Dor & Doron, 2015). It is worth noting that a body of research examining adult support capacity, partner relationships and psychological disorders has subdivided this category into 'angry-dismissive' and 'withdrawn-avoidant' based on the rates of anger expressed in relationships (Bifulco et al., 2002). The angry-dismissive style is characterised by an angry avoidance of others and it differs from the avoidant/withdrawn style that appears to be rational and non-emotional.

A *preoccupied* attachment style contains a negative view of self and a positive view of others. Individuals high on attachment anxiety tend to display hyperactivating attachment styles which are characterized by a tendency to intensify negative emotions and be particularly attentive to threats (Bartholomew, 1991; Bartholomew & Horowitz, 1991). Typically, when engaging in supportive relationships individuals with preoccupied attachments tend to perceive others as less supportive and responsive to their needs (Ein-Dor & Doron, 2015).

Finally, individuals with *fearful* patterns of relating to others tend to have a negative image of both self and others. Fearful attachment styles are linked with negative expectations of self and others and exhibit a combination of avoidant and dismissive characteristics (Ein-Dor et al., 2015). Patterns of behaviour manifest in an incoherent and chaotic style when under stress, and behaviours are a mix of help seeking and help rejecting attitudes, which consequently may elicit unhelpful responses from others (Carlson, 1998; Danquah & Berry, 2014). Because the fearful category represents a mixture of anxious and avoidance dimensions, it has been sometimes linked to the concept of disorganization (Mikulincer & Shaver, 2007; Simpson & Rholes, 2002).

Attachment styles have been previously incorporated in several models of psychopathology and amongst others have been examined in relation to coping strategies and emotional regulation capacities prior and in the aftermath of trauma. For instance, trauma theory postulates that the view of self and others are highly influenced by the

traumatic events in early and later life, which has an impact on coping styles (Jeavons &Greenwood, 2007) and symptomatology in later life (Janoff-Bulman, 1992; Muller et al., 2000). This meditating role of attachment in the relationship between regulating emotions and coping with trauma will be further explored in the following section.

3.2 Attachment functioning and emotion regulation

For decades, research has been focused on understanding individual differences, strategies employed and factors that may advance or impair one's ability to respond to traumatic events in positive ways. In fact, the way people may regulate or interpret traumatic events can be significant determinants of later adaptation and particularly influential in the development of psychopathology. A number of studies have explored the association between several emotional regulation strategies and aspects of prolonged distress (see for example van der Kolk et al., 1996; Cloitre et al., 2005). However, the reasons why people may be predisposed towards a specific set of strategies is not clear within literature. Attachment theory offers a framework for gaining an insight into those individual differences in relation to the choice of strategies exercised. In particular, it has been suggested that an individual's attachment style is construed by a behavioural system and a set of predictable strategies as a means of regulating distress (Mikulincer et al., 2007).

The concept of emotion regulation refers to a set of strategies for coping with stress and regulating emotional experience (Thompson, 1994). Those strategies may refer to cognitive, emotional and behavioural ways of coping. Overall, in the context of early-onset interpersonal trauma, the emotional regulation strategies related to experiences of prolonged distress may include: emotional expression and attendance to support networks (Van de Kolk, 2003); difficulty in acknowledging and processing emotion (Cloitre et al., 2005; Briere & Richards, 2007; Chapman & Ford, 2008); emotion focused coping and blunting coping strategies (Batten et al., 2001; Tull et al., 2007); substance use and PTSD (Cohen et al., 2006; Ehring et al., 2010); disassociation and high avoidance (Van de Kolk, 1996). It has been theorised that the choice of a specific strategy for managing and coping with stress is associated with the attachment style that has been developed throughout the life course. In fact, the experience of vulnerability and distress reactivates early attachment experiences (i.e. IWM) as theorised by Bowlby and the emotion regulation strategies that may be associated with them (Gutterman et al., 2006; Mikulincer & Shaver, 2007).

Mikulincer and Shaver (2003, 2007) developed a model of adult attachment system functioning that further explains the interactions between those internal strategies for coping with distress and attachment patterns. This model, that will be explained in detail

within this section, has been used as the conceptual framework in a large body of studies which have explored the role of attachment on the development of a number of mental health disorders and substance misuse (Crawford et al., 2007; Ein-Dor et al., 2010; Catanzaro & Wei, 2010). To date, Mikulincer and Shavers' meditational model is one of the few models that assess coping strategies by taking into account both the attachment experience and its modifying effect on outcomes related to complex trauma.

Bowlby (1973) theorised that in the event of a threat the person affected seeks proximity to important others for alleviating distress and gaining the lost sense of security. When those needs are met, the developing working models of self and others follow a set of organised and stable patterns that account for positive adaptation and good psychological functioning (Mikulincer & Shaver, 2007). In this case, we may say that the individual develops a set of effective strategies to cope with distress. Those are organised around a 'secure base script' that has the potential to increase resilience and offer a set of skills for stress management, trauma processing and sustained emotional well-being (Waters & Waters, 2006). On the other hand, when attachment figures are unavailable, unresponsive or neglectful, secondary strategies develop that can be conceptualised under two forms: the *hyperactivation* or *deactivation* of the attachment system. Those strategies are primarily adaptive, since their main role is to promote proximity to caregivers and decrease the levels of psychological distress. However, it has been suggested that in cases where the caregiver is also the source of danger and distress, such as in cases of emotional and physical neglect and/or abuse, the developing set of strategies tend to be highly disorganised and can result in poor psychological adjustment (Hesse & Main, 2006).

Specifically, *hyperactivation* refers to excessive vigilance around potential threats and a tendency to overthink and ruminate on one's previous traumatic experiences. A significant characteristic of individuals that may adopt hyperactivation strategies is that they tend to be over dependent, see others as less supportive and attentive to their needs, and consequently perceive the self as helpless (Shaver & Hazan, 1993; Mikulincer & Shaver, 2003; Collins & Freeney, 2004). As a result of long-standing aversive mood states and intense fear of potential environmental threats, the attachment system remains highly activated (Bowlby, 1973). The ability to regulate emotions is markedly impaired and individuals may also come across as coercive and aggressive in their relationships with others (Mikulincer & Shaver, 2003).

In contrast, the *deactivation* process of the attachment system is associated with psychological distancing and suppression of stress and emotions (Mikulincer & Shaver, 2007). Individuals that employ those strategies avoid help from others out of fear of

rejection and hold a defensive, dismissive and distrustful attitude when relating to others. Ein-Dor et al. (2010) recognise that distancing strategies may be effective in cases of low and mild distress; however, in cases of more severe forms of distress, especially when these remain unresolved, those strategies are particularly destructive and can further impair the ability to respond to future stressors. Consequently, attachment avoidance has been linked with alienation from social networks, instability in relationships, and inflexible attitudes which may lead to experiencing feelings of anger and rejection.

The above model places an emphasis on the significance of secure early attachments for developing a sense of security and confidence in self and others. Similarly, studies deriving from the resilience field have also conceptualised attachment security as a determinant factor of the development of resources for social adjustment and psychological well-being in early and later life (Luthar & Cicchetti, 2000). The model expands Bowlby's theory and reflects both the significance of attachment security and the strategies employed to deal with threats and previous trauma. *Hyperactivation* or *deactivation* strategies influence individuals' defences in relation to the view of self and view of others and may account for the presenting behaviour. Furthermore, a number of commentators suggest that it can provide a relational framework for understanding complex developmental trauma within therapeutic relationships (Pearlman et al., 2005; Courtois & Ford, 2009).

3.2.1 Trauma and attachment styles

Much of the attachment literature has been primarily focused on investigating the quality of early attachments in relation to later mental and emotional development. As noted above, research has consistently revealed that when early attachments with prime caregivers are disrupted, insecure attachments are likely to develop. A strong association between insecure states of mind in relation to attachment style and reports of histories of childhood adversity in clinical and non-clinical samples in adulthood has been identified (Muller et al., 2000; Stalker et al., 2005; Stovall & Cloitre, 2006; Carr et al., 2010). From a trauma theory perspective, attachment styles have been associated with the level of trauma exposure. This is attributed to the impaired ability to regulate internal psychological experiences (Pearlman, 1998) and the development of inefficient emotion regulation strategies (Bowlby, 1980; Burns et al., 2010). Much of the attachment literature is focussed on interpersonal trauma occurring in early years and particularly on experiences of abuse, neglect and physical maltreatment within the family environment. It has been suggested that childhood trauma shapes individuals' styles of relating to others in later life. In fact,

it has been proposed that vulnerability is linked to internal schemas (mentioned above) that one develops about themselves and others.

In particular, a great number of studies have established that there is a prevalence of insecure attachments in adult populations with experience of adversity in childhood and support the argument that attachment interplays with and affects adjustment outcomes (Stalker et al., 2005; Stoval et al., 2006; Riggs et al., 2007; Carr et al., 2009; Muller et al., 2012). A number of studies have also integrated insecure attachments to current models of posttraumatic symptomatology following ACE (O'Connor et al., 2008; Arrikan et al., 2016). Muller et al. (2000) have suggested that this is a plausible link as both PTSD and attachment problems are related to a lack of felt security in interpersonal relationships and ability to regulate emotion. The majority of studies exploring the link between PTSD and insecure attachments in populations with histories of child abuse have shown consistency in their findings despite great variations in the methodology used to measure adult attachment (see Stovall-McClough et al., 2006; Riggs et al., 2007).

Researchers tend to investigate adult attachment either through an interview process or via self-report measurements. As far as interview processes are concerned, the Adult Attachment Interview (AAI) is the most popular and well-established measure of attachment. AAI is primarily focused on the parent-child attachment and through discourse analysis it attempts to explain current attachments through past attachment styles in early life. Stovall-McClough and Cloitre (2006) used AAI to assess PTSD symptoms in women with histories of abuse (n=30). In a breakdown of the four-way classification, they revealed that over half of the sample (57%) were classified as having unresolved states of mind for participants reporting abuse and/or loss, and 21% were classified as having a dismissive or preoccupied attachment style. The AAI was also used by Riggs et al. (2007) in assessing a sample of inpatients (n=80) in a specialised treatment program that was focused on trauma-related disorders. They identified the following attachment styles: 7.5% of the sample was securely attached, 10% was either classified as dismissive or preoccupied, while 80% was identified as unresolved/disorganised.

Similar to the above studies (Stovall-McClough et al., 2006; Riggs et al., 2007), researchers that use self-report attachment measurements tend to also examine the relationship between attachment styles and trauma symptomatology (see Allen et al., 1998; Riggs et al., 2007; Erozkan, 2016). Self-report measurements derive primarily from the social psychology perspective as opposed to the development psychology perspective that underpins AAI. The distribution of attachment styles recorded is not vastly dissimilar, and most studies report that the majority of individuals with a history of early trauma tend to

fall into the fearful, that can resemble the unresolved/disorganised category. For instance, Riggs et al. (2007) in a study using inpatient samples (n=80) found that 58% of participants were classified as having a fearful style, whilst slightly higher rates (68%) were reported in a similar study by Allen et al. (1998).

In non-clinical samples, greater variations in insecure attachment styles have been noted, although fearful and dismissive attachment styles have consistently shown a positive correlation with PTSD symptomatology (Waldinger, Schulz, Barsky, & Ahern, 2006; O'Connor & Elkit, 2008). For instance, Muller and colleagues (2000) explored the relationship between attachment style and PTSD symptoms in a community sample who reported experiences of childhood abuse. They identified that the dismissive style was prevalent (42%), followed by 21% of participants assessed as having a fearful attachment style. Analysis of variances showed that those who displayed fearful and dismissive attachment styles (which represent a negative view of the self) had the highest mean scores on PTSD symptomatology. Similarly, in O'Connor et al.'s (2008) study of a young adult population (n=328 students), analysis showed that one particular attachment style, the fearful, could explain part of the variation of the PTSD symptomatology. It was suggested that fearfully and dismissively attached individuals displayed higher levels of lifetime and current number of PTSD symptoms and were related to poorer psychological adjustment (O'Connor et al., 2008). On the other hand, those with a preoccupied attachment style had the lowest mean scores of PTSD symptomatology and psychological adjustment (O'Connor et al., 2008). Research deriving from the social psychology field has also suggested that disorganised attachments (containing elements of attachment anxiety and avoidance) are also important links between trauma and later outcomes. In a recent study that looked into the mediating effects of attachment between early trauma and later adult externalising outcomes, disorganised attachment patterns appear to be a strong mediating factor (Rholes et al., 2016).

Researchers argue that there is also an association between heightened psychological distress and avoidant coping strategies (O'Connor, 2008). For instance, previous work has indicated that complex trauma survivors may use a number of defensive psychological mechanisms to cope with emotions evoked by traumatization often resembling the clinical picture of dissociation[2] (Hesse & Main, 2000). A number of studies have actually identified a link between cumulative trauma occurring in early years with

[2] According to DSM-5 of mental disorders (2013) dissociation is characterised by a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment.

unresolved/disorganised attachment styles and dissociative processes in adulthood (Liotti, 2004; Steele et al., 2013). Overall, evidence from both the attachment field and trauma theory suggest that experiences of complex trauma will shape the attachment style in early life and adulthood which in turn will have an impact on coping mechanisms and development of psychopathology. To gain an understanding of how this has been conceptualised within existing research findings, an overview of literature that links attachment dispositions to mental-health disorders follows.

3.2.2 Attachment styles and mental health

A range of studies have reported that insecure attachment styles are inextricably linked with mental health difficulties and vulnerability to psychiatric disorders. Multiple studies of both clinical and non-clinical samples have established a link between insecure attachment dispositions and depression (Bifulco et al., 2002; Rayburn et al., 2005), generalised anxiety disorders (Marganska et al., 2013; Schimmenti et al., 2015), personality disorders (Fonagy et al., 2011; Levy et al., 2015), psychosis (Berry et al., 2007), and suicide ideation (Davaji et al., 2010; Lizardi et al., 2011). A growing body of empirical research has also examined the link between attachment insecurity, conduct disorders and substance misuse, and results have often indicated a positive association between those variables (Caspers et al., 2006; Krueger et al., 2011).

Researchers have further explored distinctions within attachment styles in order to identify potential associations between attachment categories and mental health. In fact, it has been suggested that there are emerging patterns between particular attachment dispositions and sets of symptoms. For instance, dismissive attachment styles have often been associated with conduct disorders (Rosestein et al., 1996; Vungkhancing et al., 2004) and anxious states of mind with depressive symptoms (Wei et al., 2005). Further to this, disorganised attachments have previously been linked with more severe forms of psychopathology, as evidenced by the high rates of unresolved trauma and losses that are often reported by individuals with disorganised attachments (Hesse et al., 2000). For example, individuals with these dispositions due to traumatic memories of previous attachment relationships are far more likely to experience dissociative and personality disorders (Tyrrell et al., 1999; Liotti, 2000, 2004).

In relation to substance misuse, a strong link between avoidant attachment styles and addiction was found in a number of studies (Finzi-Dottat et al., 2003; Golder et al., 2005). An explanation for this might be that avoidant individuals tend to use deactivating strategies more often to ‘avoid’ stressful situations. Consequently, they may often engage

in risky behaviours for regulating their emotions. In studies in which the four categorical model was used (which also includes the fearful attachment pattern), the rates vary in that a higher association between fearful attachment and substance misuse was identified (McNally et al., 2003; Schindler et al., 2005; Reis et al., 2012). Researchers concluded that the difficulty to cope with negative affectivity (similar to avoidant styles) along with a number of interpersonal difficulties that have previously been associated with fearful attachments increases the risk of misusing substances. On the other hand, a small number of studies have reported a link between increased severity of addiction and anxious attachments when compared to avoidant attachments (Brummet et al., 2007). Brummet and colleagues (2007) explained those findings by suggesting that avoidant individuals may need fewer substances to detach from themselves, as they already use deactivating strategies to cope with their emotions. Although the rationale behind each style may vary, scholars agree that severely insecure attachments present a higher risk for substance misuse and emotional disengagement. The link between cause and effect, namely the causal mechanisms influencing how particular attachment styles lead to a set of mental health symptoms is as yet unclear within literature.

Furthermore, the reasons why some individuals with a particular attachment may not necessarily present with the same symptoms or with any symptoms at all, adds more complexity to the issue. Ein-Dor and Doron (2015) have recently proposed an integrative model, referred to as the *transdiagnostic model* of attachment insecurities, to explain potential links between symptoms and attachment styles. The model explains that insecure attachments, assessed as either scoring high on the avoidance scale or on the anxiety scale or both, do not increase the risk for mental health disorders per se. However, attachment dispositions along with specific psychological and socioeconomic risk factors do severely compromise outcomes of mental health in adulthood (Ein-Dor & Doron, 2015). Ein-Dor and Doron's (2014) t*ransdiagnostic* model is organised around two attachment dimensions: attachment avoidance and attachment anxiety. These are depicted as risk factors for a specific mental health disorder(s) (see Figure 3.3).

Their model considers the modifying role of emotion regulation strategies, these being hyperactivation and/or deactivation (as described above). When under stress the individual uses those strategies for regulating his or her emotions and responds accordingly to the environmental demands. The transdioagnostic model also takes into account a number of moderating factors that may determine and shape final responses based on prior and current attachment dispositions and emotion regulation strategies.

Those moderating factors include experiences of loss and trauma, negative reinforcement and/or observational learning through family and peers, and growing up in an adverse and impoverished environment (Ein-Dor & Doron, 2015). In the model, psychopathology is associated with insecure attachments through a set of environmental factors which create the necessary conditions for insecure attachment styles to develop. In all, Ein-Dor and Doron's conceptualization of attachment dispositions contributes to our understanding of psychopathology by proposing that symptoms develop only when a person is faced with specific moderating factors. In this vein, in disadvantaged populations, the added stress of parenting and living in poverty and the prevalence of unresolved trauma, losses and ACEs are significant indicators of later psychopathology and substance misuse (Stein et al., 2002; Seaman, 2005; Ridge, 2009).

Figure 3.3 Transdiagnostic Model by Ein-Dor & Doron (2015). Source Ein-Dor & Doron (2015), p. 355.

All things considered, it might be particularly useful to have this model in mind when attempting to conceptualise the modifying effect of attachment in the causation of MEH. A number of researchers in the field of housing and homelessness suggest that all the factors mentioned above (poverty, ACEs, trauma, interpersonal loss etc.) are independently associated and present among individuals that face multiple exclusion homelessness in the UK (Martijn & Sharper, 2005; Shelton et al., 2009; Fitzpatrick et al.,

2011). Similarly, in the attachment informed model a dynamic interaction between individual and moderating factors is also evidenced. Ein-Dor and Doron's (2015) model offers some new perspectives by identifying obvious relational links among moderating factors (i.e. ACE, disadvantageous environments etc.), attachment dimensions and mental health outcomes. As expected, each set of factors influences the outcome in only a somewhat predictable way, as human agency is characterised by unpredictability and variability. The question though that remains unanswered is whether attachment styles and related experiences have a modifying effect on the causation of complex forms of homelessness in ways not previously taken into consideration?

3.3 Attachment and Homelessness

To date there have been very few studies examining homelessness through the framework of attachment theory. Those that do exist have primarily focused on the overview of causal, protective and risk factors. Most empirical studies derive primarily from the US and have either investigated the relationship between attachment security and homelessness in homeless mother-child dyads (Becker 1994; Bassuk et al., 1997; Easterbrooks & Graham, 1999; Smolen, 2013) or the role of attachment as a risk factor for youth homelessness (Rew, Taylor-Seehafer, Thomas & Yockey, 2001; Stefanidis, Pennbridge, MacKenzie & Pottharst, 1992; Tavecchio & Thomeer,1999; Taylor-Seehafer et al., 2007, 2008). It is worth noting that there is also a small number of unpublished quantitative doctoral theses which have explored the mediating role of attachment in the lives of homeless individuals in relation to a number of personality-constructs (Franskoviak, 1999; Ron, 2004; Selwood, 2012; Mongomery-Graham, 2015).

Overall, this empirical evidence indicates that there is a high prevalence of dismissive attachment styles within homeless populations (Franskoviak, 1999; Vinay et al., 2011; Selwood, 2012; Montgomery-Graham, 2015). However, the majority of these studies have used a three-categorical self-report measurement, thus fearful or unresolved/disorganised attachment styles which have previously been associated with traumatised populations were not taken into account. Supplementary to the lack of consistency in measuring attachment, current literature conceptualises attachment in a variety of forms hence results are not often comparable. For instance, studies may explore attachment related constructs such as social connectedness (Taylor-Seehafer et al., 2007), or attachment history (Stefanidis et al., 1992), and occasionally attachment styles (Seehafer et al., 2008; Vinay et al., 2011).

In detail, in relation to attachment in homeless mother-child dyads, only a few studies were identified. In one of those, differences of housing status and characteristics of parenting, or security of attachment were assessed and compared between low-income families and homeless families (Easterbrook et al., 1999). Results were primarily analysed in relation to conditions of poverty and parenting styles and data were gathered via questionnaires. It was suggested that results cannot be explained by poverty alone and more research is required for unravelling the effects of homelessness on a child's developmental stages. Smolen (2013) also assessed the relationship between homeless mothers and their children but this time using an interview protocol (AAI). Scores indicated a high number of insecure relationships (86% of sample) between homeless mothers and their children. Smolen suggested that the relatively inflexible emotional relationships and past traumatic experiences that characterised those mothers can account for the high levels of insecurity. She further writes (2013, p. 78):

> "Parents who have unresolved traumatic histories often find their children's emotional needs overwhelming […] when an infant lives with strain trauma, such as poverty, neglect and homelessness, an acute trauma becomes magnified because the infant does not have the ego defences, self-structures, and actual relational and social support necessary for flexible adaptation to challenges from the environment".

In relation to homeless youth, results differed in that a high prevalence of insecure attachments styles were noted. Tavecchio and Thommer (1999), for example, conducted a comparative study in the Netherlands amongst 108 homeless young people, 85 young individuals being in residential care and a large control group (n=1,228) from the general population. They identified a set of risk and protective factors as indicators of the quality of attachment over the life course that may account for the causation of runaway youth and homelessness. Quality of attachment was measured through three factors: responsiveness of caregivers, number of separation experiences and severity of separation experiences. Their hypothesis was based on the link between the quality of early attachments, their impact on later psychosocial development and the degree of quality of current relationships. The study made a compelling argument by indicating significantly high levels of insecure attachments amongst homeless youth and youth in residential care when compared to the general population.

As far as attachment styles were concerned, studies have reported a high prevalence of avoidant or dismissive attachment styles amongst young homeless people and indicate

how those predispositions (when relating to others and social support) can act as a risk factor for runaway youth. For instance, in Vinay and colleagues' (2011) study, almost half of the homeless sample were assigned to the dismissive style category, and those findings were further supported by a number of preliminary studies with similar outcomes (Franskoviak, 1999; Selwood, 2012; Montgomery-Graham, 2015). In attempting to explain this correlation, Schmitt (2008) offers a perspective informed by evolutionary theories. He suggests that in adverse environments the prevalence of dismissive attachment styles may be due to the need for adaptation. Avoidant attachment styles may play an adaptive role when responding to dismissive family environments and act as protection to further potential neglect and rejection. A different perspective, though, was suggested by Tavecchio and Thommer (1999). They argue that homeless populations have often been identified as a group which lacks the capacity to develop trustful supportive relationships, thus avoidant behaviours will be common.

The causative role of parental unresponsiveness, early onset trauma and lack of adequate emotional support were also referred to as major contributing factors to pathways into homelessness (Tavecchio & Thommer, 1999). In those cases, researchers have been suggesting that the expansion of current social networks and development of secure attachments with appropriate services could act as a protective factor for counteracting youth homelessness. Nonetheless, the more severe the attachment dysfunction the more difficult it is to achieve change. For instance, the Stefanidis et al. (1994) study pointed at the importance of the severity of attachment histories for improving outcomes. The study looked at three groups of homeless youth aged between 12 to 17 years, living in the US. The groups distinguished between: youth that had actively pursued a stabilization goal, youth that had left the programme, and youth whom had successfully maintained their placement. Statistical analysis indicated that negative attachment experiences were prevalent within groups that were less able to move off the street (Stefanidis et al., 1994). Additionally, negative attachment experiences were identified as being an important risk factor when associated with exiting and re-entering the homeless lifestyle. Stability in current accommodation was associated with positive attachment experiences, greater ability to ask and receive support, lower levels of mistrust and avoidant attitudes towards others and lower scores of depressive symptoms (Stefanidis et al., 1994).

A small number of studies have also examined attachment in homeless populations in relation to the length of time being homeless (Franskoviak, 1992; Aliverdia & Pridemore, 2012). Aliverdia et al. (2012) explored family attachments among adult males in Iran and concluded that insecure family attachments are associated with a greater amount

of time spent homeless. A study by Franskoviak (1999) also suggested that the individuals with avoidant and fearful attachment styles had the longest average periods of being homeless. This might be explained by Mikulincer and Shaver's (2003, 2007) model, in which a negative view of others is interlinked with fearful and avoidant relating patterns thus relationship and engagement with support tends to be impaired.

Finally, a few studies have examined attachment experiences in relation to trauma, substance misuse and sexual health behaviours among homeless youth (Taylor-Seehafer et al., 2007, 2008; Kang & Glassman, 2009). Those studies used attachment–related constructs such as social support and social connectedness (as opposed to attachment styles) to inform their outcome measures. In the Taylor-Seehafer et al. (2008) study, although attachment was not strongly correlated with social connectedness and substance misuse, researchers found a surprisingly high prevalence of unresolved-disorganized attachment patterns (measured via AAI) among homeless youth. Results indicated higher numbers of the disorganized attachment pattern when compared to findings from previous studies of adolescents in psychiatric units (see Allen et al., 1996). In youth with a disorganised style, patterns of behaviour manifested in an incoherent and chaotic style when under stress and behaviours involved a mix of help-seeking and help-rejecting attitudes. However, this was a small scale study (n=27), thus it is hard to draw any wider conclusions on the prevalence of unresolved/disorganised attachments amongst homeless populations. Nonetheless, disorganised or fearful patterns of relating appeared to be more prevalent in populations reporting ACE (see Efron, 2006; Cyr, 2010; Stronach et al., 2011).

Despite the fact that there is a clear argument for the high prevalence of insecure, and potentially disorganised, attachments in traumatized populations there is a clear gap in studying attachment and using a four-category model in homeless populations. Moreover, in homelessness research the presence of structural causes such as economic disadvantages and poverty are additional risk factors to be considered. Attachment literature suggests that poverty is associated with insecure attachments styles due to the increased possibilities of been exposed to stressful events and ineffective parenting practices (Belsky et al., 1991; Smolen, 2013). However, numerous studies have also shown that household poverty may not account for infant attachment insecurity or potential parental neglect (Susman et al., 1996; Mills-Koounce et al., 2011). On the contrary, in resilience literature emphasis was given on the buffering effects of potential positive family resources that may also develop in conditions of adversity (Conger& Conger, 2002; Walsh, 2012).

Overall, attachment research in homeless populations has been limited despite the increased risks and adversities that this population face. It is evident that despite the high

prevalence of childhood trauma in MEH populations, its impact on behaviour and relating patterns when engaging with support services has not been examined to date. Poverty, stressful events and ACE are all significant contributors to the development of attachment-relevant stressors. However, the modifying effect of attachment when attempting to understand the patterns of engagement of MEH with housing and street-outreach services has not been explored. This project seeks to address this gap by providing a conceptual framework which is shaped by an adult attachment model and by empirically exploring the attachment styles and attitudes of MEH populations.

3.4 The role of attachment in service engagement of vulnerable populations

As noted above, attachment research has consistently reported that the most disrupted attachment styles are associated with greater difficulties in social functioning and accessing support, hence relationships with care are compromised by insecure attachment styles. Alexander and Anderson (1994) proposed a model that relates attachment styles to responses to treatment. It is based on the idea that difficulties in engaging with support may be due to past negative relational experiences and support services need to eventually adjust to the relational patterns of the targeted population in order to improve outcomes (Barber et al., 2006). In a sense, this model 'makes predictions' about service users' behaviours and engagement styles. It suggests that service users with attachment difficulties will have poorer responses to standard treatments, thereby alternative ways of relating should be adopted.

For instance, service users with preoccupied attachment styles that may have difficulties regulating their emotions and often feel overwhelmed by them, may benefit more from interventions that maximise the focus on practicalities and organization. In contrast, those with avoidant and dismissive attachment styles may benefit from consistent prompts to interact with others and provision of opportunities for verbalising their feelings (Berry & Drake, 2010; Alexander et al., 1994). However, those attachment needs often remain unmet and mental health and relevant services are not always taken them into consideration when designing and delivering services (Bucci et al., 2015). For instance, in therapeutic settings, Mikulincer, Shaver and Berant (2013) argue that those needs seem to be often ignored despite evidence indicating that attachment styles influence the engagement processes with staff members. Thus, it is not surprising that those needs may be further neglected by homeless services, despite their direct contact with complex and traumatised individuals.

Many service users with experience of MEH have experienced trauma and their contact with services may lead to further traumatization when services fail to offer *"effective containment of anxiety modulation through structure, consistency, and predictability"* (Bagshaw et al., 2012, p. 190). This particularly vulnerable group, within which high levels of insecure and dysfunctional attachment may be found, often presents with acute interpersonal problems that compromise their recovery. A key question that arises here is: are support services aware of the specific attachment needs that are prominent in MEH populations? Similarly, could psychodynamic frameworks such as attachment theory prove helpful in understanding how people with experience of MEH relate with support services? This project will seek to address these questions and advance understanding of the mechanisms by which MEH populations engage with support services. This section thus will be reviewing current findings on the development and implementation of any attachment-informed and psychologically-minded approaches within homeless services.

3.4.1 Attachment informed approaches in services

Developing a secure base either with an individual (or a place) requires continuity, availability, flexibility and responsiveness (Bowlby, 1969). Evidence-based research in relation to applications of such an attachment framework when working with 'difficult' populations derives primarily from the mental health field (see Berry & Drake, 2010; Seager, 2011). Additionally, a similar model has been carried out for informing and designing secure settings in forensic institutions (see Adshead, 2002; Barber et al., 2006). Those reviews place most emphasis on the transformational nature of relationships developed between service users and clinicians, mental health professionals, therapists or prison staff. In this vein, besides the significance of stimulating secure attachments with service users, an 'attachment to place' is also introduced (Goodwin et al., 2003). That is to say, that a whole service or a team could act as an 'attachment figure' for clients and it might be more accurate to think of 'service-to-client' attachments (Goodwin et al., 2003). This is very much in line with the PIE approach in which the whole service aims to provide a psychologically safe environment for the service users (see Chapter 2).

Bucci et al. (2015) provided a comprehensive theoretical review on how attachment informed environments could be conceptualized within mental-health services. Their review identified key themes that are impacted by an attachment framework, namely: service policy and evaluation processes; referrals; assessments and formulation; interventions; support for staff and informal carers; issues around moving on, and service

benefits (Bucci et al., 2015). Overall, reliability and consistency in relationships between staff members and service users were identified as the most influential aspects of care. Research further proposes that 'corrective' emotional experiences through secure attachment relationships with service users might challenge and modify the negative view of self and negative view of others and thereby improve their engagement levels with a service (Schuengel et al., 2001; Adshead, 2002). This is a particularly important finding considering the potentially high prevalence of insecure attachments within homeless populations and their influence on an individual's levels of engagement and ability to respond to support (Maguire et al., 2009).

However, within the homeless sector there is extremely limited evidence demonstrating the outcomes of the implementation of an attachment-informed service. A single pilot project run by St Mungo's explored whether psychodynamic interventions (including attachment) could reduce exclusion and improve outcomes (Cockersell, 2011). In this, an attachment-informed approach in managing relationships was implemented in a first stage homeless hostel. In parallel, one to one psychotherapy sessions were offered to 'adults facing chronic exclusion' for addressing their attachment insecurities. Demographic results indicated that a strikingly high number of participants disclosed that they experienced an ACE (74% childhood abuse and 34% early abandonment and loss of a parent). Upon implementation of the approach, some very positive outcomes were reported, including a higher attendance rate (76%) for clients that were deemed 'difficult to engage'. Furthermore, outcomes appeared to be particularly improved in relation to employment and educational development (Cockersell, 2011). The study's soft outcome measurements such as the *Outcome star* and *Cycle of change* (for a review of soft measures see Anderson, 2008) showed some promising results.

3.4.2 Staff responses and attachment styles

Research with homeless populations and people with complex needs has highlighted the relational breakdowns and difficulties that these populations face and the potentially transformational role of relationships in engendering positive outcomes (Anderson, 2011; Fitzpatrick et al., 2012; Bramley et al., 2015; Balda, 2016). The national advisory group on mental health and well-being (2007, p. 3) states:

> "Vulnerable service users will always bring their own attitudes into the relationship and this can create a positive or a negative interaction with carer attitudes. These

psychological interactions are always present and are always critical to outcome regardless of the particular techniques, models or approaches that might be used".

The barriers and challenges that homeless and crisis services encounter when working with 'difficult' populations are very much related to the affect-based behaviours that clients present with. As expected, those that are most frequently exposed to the negative effects of service users' behaviours, emotional reactions, and even violent outbursts are the staff members that work with this often called 'challenging' client group. An important part of their work is to have a good understanding of their clients' needs and to be able to maximise the potential to form a trusting relationship. In that sense, awareness around attachment patterns and strategies are beneficial. Bagshaw et al. (2012, p. 191) argue that *"the usefulness of the concept of attachment style in care planning and treatment relies heavily on the ability of staff to identify these characteristics consistently"*. However, most staff members are not aware of attachment related constructs and the application of such approaches appears to be very limited.

It is worth considering that most of the above suggestions derive primarily from the mental health field and are meant to improve the therapeutic process with highly traumatised individuals. However, the relevance to the work with MEH populations is clear. It is envisaged that in the homeless sector, an attachment-informed environment could assist staff members to identify, predict, and counter challenge posed by service users presenting with relational/attachment difficulties. With regard to her research on attachment patterns on homeless mothers, Smolen (2013, p. 43) writes, *"[...] these patients, far from being emotionally 'hard to reach', often challenge our poise and defences with communications that 'reach' us forcefully"*. In this respect, there is a need for staff members to be aware of their own attachment styles or difficulties, which may be more prominent when challenged (Berry & Drake, 2010). This is due to the fact that service users that hold dysfunctional attachment styles are highly likely to challenge the internal resources of staff and push and/or test their boundaries (Dozier et al., 1994; Adshead, 2002; Bagshaw et al., 2012). For instance, evidence stemming from psychiatric services across the UK suggest that lower levels of staff anxiety and avoidance are related to more positive therapeutic relationships, while insecure attachment styles amongst staff are associated with insensitive and more rigid interactions, which can lead to problematic styles of relating (Berry et al., 2008).

A number of strategies have been proposed to foster the creation of a holding and supportive environment that can act as a secure base and/or increase staff members' ability to respond in ways that do not further traumatise individuals. Dozier et al. (1994) suggest

that clients with complex interpersonal problems have developed coping styles that are not 'adaptive' in the relationships with clinicians, staff members, and services in general. As a result, at first stages staff members are those who need to 'match' their approach to the clients' attachment needs by identifying service users' attachment style and responding accordingly (Barber et al., 2006; Berry & Bucci, 2015). In this vein, the role of professionals is to disconfirm negative working models within the context of a secure base (Dozier et al., 1994; Pearlman et al., 2005). For instance, service users that have a dismissive and avoidant attachment style may present themselves as highly self-reliant and invulnerable, while they may often push others away. In those cases, staff members may respond by being less attending to them resulting in missing the underlying needs of those clients (Dozier et al., 1998). On the other hand, preoccupied and enmeshed clients often come across as fragile, needy, and dependent (Alexander et al., 1994; Dozier et al., 1994). In those cases, evidence has shown that staff members tend to respond accordingly by being more careful and considerate (Dozier et al., 1998). Both those responses tend to reconfirm service users' existing working models, previous expectations and beliefs about relationships and thus might not necessarily be helpful in the long-term.

The capacity to be able to respond without being pulled into those often emotionally-draining interactions and assist clients to make use of the support offered, often lies to some extent in understanding the relevance of attachment theory in social interactions (Dozier et al., 1994). For instance, dismissive and avoidant service users may benefit from interactions that encourage them to verbalise their needs through a stance of ongoing support, exploration, and neutrality, as opposed to defensiveness (Pealrman et al., 2005; Berry & Drake, 2010). Alexander et al. (1994) suggested that a frame of neutrality and curiosity can be a very useful strategy to adopt in working with those clients as it can act as a way of reconnecting with the client. In contrast, those clients that have an enmeshed and preoccupied attachment style that are often overwhelmed by their emotions and tend to present as helpless and over-dependant may benefit from an approach that pays less attention to emotions and adopts a more pragmatic and practical stance (Alexander et al., 1994; Berry & Drake, 2010). The eventual goal is to foster engagement with service users via modelling a therapeutic relationship in the sense that staff members are working in a partnership model with service users and able to adopt a more user-led approach (Wright et al., 2011).

To achieve this, the concept of reflective practices, where the internal resources of staff members are considered closely, have proven very promising. In particular, a number of studies have drawn attention to the need for developing reflective staff groups and

consultations to avoid the re-enactment of trauma, understand interpersonal difficulties and distressing symptoms, and maintain clear boundaries without coming across as insensitive or hypersensitive (Dozier et al., 1994; Berry & Drake, 2010; Joseph et al., 2012). In this sense, the type and nature of staff members' cognitive and emotional responses to service users with marked insecure attachments can often determine the type of interaction that takes place. For instance, in a study that looked into the attachment styles of psychiatric staff and how they can influence patient outcomes, Berry et al. (2008, 2010) reported that staff avoidant styles impact on the ability to make inferences about patients' behaviours. This lack of sensitivity had an adverse effect on relationships as opposed to more anxious staff members that had a tendency to be hypersensitive. Findings also suggested that anxious or avoidant staff usually rated patients as more secure, thus saw their attachment needs as less prominent than they actually were due to the lack of insightfulness (Berry & Drake, 2010).

In another attempt to map current working practices, Juhila (2009) suggests that staff members may develop their own 'interpretative repertoires' of theory and practice in response to challenging behaviours. Juhila (2009) evidenced a number of those repertoires when social welfare workers in the UK provided vivid descriptions of their work and encounters with homeless women. Those included: repertoire of care, repertoire of assessment, repertoire of control, repertoire of therapy, repertoire of service provision, and repertoire of fellowship. Juhila (2009, p. 140) suggests that a flexible attitude is necessary, which refers to the ability of the workers *"to read sensitively the situations and to position themselves according to situational demands"*.

For instance, individuals with disorganized attachment styles may present increased levels of hostility, challenging behaviours, and eventually poor engagement levels (Alexander et al., 1998; Mikilincer & Shaver, 2007). Those clients may cancel appointments repeatedly, disclose too much too soon, impulsively express rage, and/or adopt a vulnerable stance within a single interaction. In therapeutic environments, clinicians are called to show tolerance to those behaviours, work on repairing the relationship over and over, and proactively engage the clients in a therapeutic alliance (Berry & Bucci, 2015). In PIEs, those attitudes may be partially adopted by staff members by recognizing the significance of a relational approach in daily interactions with service users (Pearlman et al., 2005).

Finally, literature acknowledges the potentially traumatizing nature of working with '(di)stressed' and traumatized individuals that can often lead to staff feeling exhausted, overburdened, and over-responsible (Anderson et al., 1994; Scanlon & Adlam, 2012; Bucci

et al., 2015). This highlights a clear need for staff support, opportunities for reflection, supervision, and training. Working with traumatised individuals entails many relational challenges and this can have a secondary effect upon workers and teams in the form of vicarious trauma. In attachment terms, those challenging behaviours may be both a way to seek attention from 'caregivers', and also an expression of anger and distress as a result of 'perceived abandonment'. An attachment framework might therefore offer detailed guidance and shed light on those underlying mechanisms underpinning the often 'chaotic' relational patterns of individuals with experience of MEH. That is not to say that direct links between attachment styles and service users' precise behaviour should be expected, but rather that a more sophisticated understanding of the relational difficulties and challenges of MEH populations may be beneficial.

Conclusion

This review summarises current research findings and knowledge about the significance of attachment theory for understanding patterns of behaviour and strategies for regulating distress and managing adversity. Existing research suggests that high levels of insecure attachment and poor interpersonal relationships are present amongst homeless populations. The backgrounds of individuals that have experience of homelessness and related forms of exclusion often includes chronic childhood trauma that intersects with and adversely affects their personal and interpersonal resources. Given the likelihood of re-enactment of unsupportive relationships in other contexts, interventions with a focus on relational issues and vulnerability can be particularly useful for supporting complex clients within their specific social context (Bifulco et al., 2002). It is evident that *"no one is more in need of help with attachment and regulation than those who have been chronically abused and neglected in childhood"* (Danquah & Berry, 2013, p. 78). However, at present there is a profound lack of evidence around the attachment predispositions of individuals experiencing MEH as adults and the role these play in mediating their relationships with support.

Furthermore, empirical research suggests that relationship breakdown is commonly reported as an important factor for being homeless and thus it is likely that the modifying effects of attachment may play a role in the causation of homelessness. The relationship between ACE and attachment experience in highly vulnerable populations has not yet been rigorously investigated. In a population where a significant number of service users may 'fall through the gaps' and are deemed as 'challenging' in developing and maintaining contact with support, an attachment perspective has the potential to inform the development

of more sophisticated approaches and *"bespoke services tailored to their (service users') specific needs"* (Fitzpatrick et al., 2013, p. 163). At present, the lack of a clear conceptual framework that explains how and why some individuals may be more likely to present with more complex needs than others which in turns influence their relating patterns, poses an obstacle in improving service quality and in fostering recovery.

Finally, the review highlighted that when attempting to address the complex support needs of MEH individuals, support services are unavoidably encountering the personal and interpersonal challenges that those individuals present with. Those challenges often pose a significant barrier for both the service users and providers. On the one hand, the lack of coordinated responses across services exacerbates exclusion, whilst in parallel practitioners feel stuck in how best to exercise their 'duty of care'. This thesis argues that essentially there is a lack of understanding of the ways that staff members but most importantly MEH individuals experience, develop and maintain relationships with support. Previous insights from attachment theory offer a plausible framework for fostering transformational relationships. It is suggested that clarity of communication, flexible attitudes, consistency in practice, adequate responses to distressed individuals, sensitivity and knowledge around the working models and coping strategies that underlie human behaviour are critical facilitators engendering positive change. However, research has only begun to look into how to adapt attachment based interventions to homeless populations and how to target attachment issues in current practice.

Chapter 4: Methodology

Introduction

This chapter provides an overview of the epistemological and ontological frameworks and the chosen methodology that underpin the study. It offers an in-depth account of the various methods used to address the specific research questions. As noted in chapter 1 the study is aiming to address the following research questions: 1. *What are the attachment styles exhibited by individuals that have experience of MEH?* 2. *What (if any) influence does adult attachment have on pathways into MEH?* 3. *How do attachment styles influence their relationship with staff members in front-line support services?* 4. *What are the cognitive and emotional responses of staff members towards service users with insecure attachment styles?*

The chapter is divided into six sections, including: a discussion of the philosophical paradigm of critical realism underpinning the study; justification of a qualitative research design; explanation of the data collection methods used; an account of the analysis; in-depth reflections regarding ethical considerations; and a discussion of the methodological limitations of the study.

4.1 Assumptions and Paradigm

The study seeks to examine the meaning that social actors give to their experiences by exploring how MEH populations engage with support services and by paying attention to the underlying psychological mechanisms that may contribute to a social phenomenon; this being the causation of MEH. In doing so, the overall approach draws on a critical realist perspective, which has become increasingly prominent in the field of social sciences and homelessness in particular (see Allen, 2000; Danermark et al., 2002; Williams, 2003; Fitzpatrick, 2005).

Critical realism (CR) is a philosophical framework that is grounded in the belief that reality is stratified and independent of our perception and cannot be limited to human knowledge in a linear and deterministic fashion. According to Volkoff et al. (2007, p. 835), *"critical realism uses perceptions of empirical events (those that can be observed or experienced) to identify the mechanisms that give rise to those events"*. Ontologically it is based on the assumption that reality cannot be reduced to epistemology and cannot be solely constructed through and within our knowledge of it (Fletcher, 2016). It further argues that epistemology results from human activity, which is inherently unpredictable in

its outcome. It acknowledges that social events are driven by a number of casual mechanisms, and aims to identify and explain these and the powers that produce them (Fletcher, 2016).

One may say that the philosophical stance of CR holds an interest in the 'unconscious processes' that are often outside of social awareness. They remain rather hidden without this compromising their existence (Williams & May, 1996). Within this study, attachment theory has been proposed as the theoretical framework for understanding social behaviour and identifying relating patterns. It has been further suggested that attachment predispositions may comprise a plausible 'hidden' contributing mechanism to the causation of homelessness. Indeed, attachment has a profound influence on the physiological and psychological development of the individual which has not been previously taken into consideration in theorization of the causes of homelessness. However, knowledge of what is known about individual and relational factors that may generate homelessness cannot be fully explained by attachment theory.

Nevertheless, attachment styles underlie behaviour and influence an individual's ability to build and maintain supportive relationships and seek help. Therefore, unpicking the role of those styles and relations in the life of people that have experience of MEH can contribute to our current knowledge on how individual factors and disadvantage interrelate and contribute to homelessness in the UK. Allen (2000) argues that when attempting to describe and explain the complexity of the interrelationships of housing and individual factors, psycho-sociological factors turn to 'integral and internal' aspects of any theorization and interpretation of the phenomenon. In particular, he suggests that multiple mechanisms (psychological, physiological and sociological) interplay and co-determine the outcome. In an attempt to explain those underlying mechanisms, the philosophical paradigm of CR is considered to be a key perspective by setting the grounds for exploring the explanatory power and plausibility of a theory, parallel to conducting empirical research.

A central ontological assumption of CR is that reality is stratified between three layers (Bhaskar, 1979, 2008). First is the *empirical* layer which refers to what is known through experience and can be empirically tested and measured. This level consists of structured concepts such as ideas, meanings, actions and decisions that have causal effects and can bring change (Sayer, 2012). The second, *actual* layer refers to the events that happen regardless of whether they are experienced or interpreted. Finally, the third *real* layer consists of underlying causal mechanisms that produce those events (Bhaskar, 2008). Those three layers of reality signify that there is one reality that may not be necessarily and

immediately accessible through empirical observation (Bhaskar, 2008). Furthermore, complex social phenomena cannot be explained in terms of mechanisms or processes working at just one level; neither are mono-causal. Critical realists argue that events are influenced by underlying causal mechanisms that operate in open and complex ways that can be highly contingent and feed back to one another (Fitzpatrick, 2005; Hood, 2015). A small change in one level alongside these complex relationships can bring about new, distinct and unexpected outcomes.

Bridging the gap between positivism and constructivism, a CR perspective does not deny that social reality can be empirically understood but further suggests that some forms of knowledge might have stronger explanatory power than others (Hood, 2015). This might be better understood in relation to a particular theory. As previously discussed, attachment may offer an explanatory framework for identifying causal interconnections that drive social behaviour among individuals that have experience of MEH and provide practical policy recommendations. It provides the orienting lens for shaping the research questions of the project, informing data collection and analysis, while also having the capacity to advance current practices and policies.

Nonetheless, attachment theory is chosen and treated as a starting point. It has been argued that CR allows for a degree of epistemological relativism where the process of scientific knowledge is viewed as *"historically emergent, political, and imperfect"* (as cited in Zachariadis et al., 2013, p. 3). The concepts used to understand the world's entities and relations vary over time and space, thus a degree of fallibility is present. The same mechanism can produce different outcomes in a different context. The goal is to constantly move between empirical data and deeper structures of reality to identify potential key causal mechanisms and agencies that produce certain behaviours (Zachariadis et al., 2013). As Fletcher (2006, p. 184) notes: *"Critical realism treats the world as theory-laden"*, while *"initial theories are facilitating a deeper analysis that can support, elaborate or deny those theories to help build a new and more accurate explanation of reality"*.

From a practical standpoint when it comes to the issue of causality, a critical realist is not simply focused on understanding 'B' as the outcome of 'A' but rather identifying the processual mechanisms and conditions that have lead from 'B' to 'A'. This process of inference refers to as *retroduction* and *"explains events by postulating and identifying mechanisms, liabilities and powers which are capable of producing them"* (Sayer, 1992, p. 107). As a result, the critical realist is concerned with explaining what it is about certain elements, factors and actions that can cause particular phenomena. In social research, identifying those underlying mechanisms that go beyond empirical knowledge and

observation, testing them out and eliminating alternative ones is a challenging process. Using homelessness as the starting point, Fitzpatrick (2005) postulated how necessary and contingent casual mechanisms interact with one another to increase 'the weight of the weighted possibility' of homelessness amongst certain impoverished people.

In particular, Fitzpatrick (2005) signified critical realism as a key theoretical framework for gaining a deeper understanding in the analysis of the causes of homelessness. She suggests that it offers an emergent, non-linear and multi-dimensional framework, which reflects the high complexity and diversity underpinning the phenomenon. The challenge lies in identifying the 'causal routes' and necessary tendencies that operate in often contingent ways to bring about homelessness (Fitzpatrick, 2005). An example may clarify this further. The high prevalence of childhood adversity and trauma among individuals that experience MEH, for instance, cannot and does not solely account for homelessness, as many individuals may be exposed to similar circumstances and experiences without necessarily becoming homeless. Childhood adversity might not be a necessary condition of homelessness, as such, but it may be within the range of casual factors that can increase the possibility of experiencing homelessness later in life. When found in combination with other factors such as poverty, substance misuse or mental health problems, the probability of homelessness substantially increases. In this vein, Fitzpatrick (2005, p. 14) explains that when *"a range of causal factors exist…then the weight of the weighted possibility for homelessness increases"*.

Events and human actions are results of casual mechanisms which often remain hidden and cannot be observed only at the empirical level. This project seeks to identify potential generative mechanisms by seeking answers to questions such as 'what is the role of attachment theory in developing a pathway into MEH?' and 'why do certain individuals tend to disengage and avoid the support that is offered?' and so on. In addressing those questions, key philosophical assumptions of CR inform the study, including: reality is stratified; social events are complex, emergent and non-linear; causation is grounded in the understanding of tendencies and generative mechanisms; and knowledge is highly contextual and to a degree fallible. The next section of this chapter will discuss the methodological steps taken to address the research questions of the project and further explore the role of CR in the empirical investigation.

4.2 Research Design

This section describes the key methodological approach adopted for the study and the philosophical paradigm that guided its design.

4.2.1 Qualitative research and the study of attachment

A qualitative research design was employed in order to explore and understand the role of attachment styles in sustaining a life on the streets and the impact of those styles and behaviour on staff responses. Traditionally, qualitative data are extremely valuable for conceptualising the reasons, experiences and strategies behind patterns of behaviour (Bryman, 2012). They offer nuanced insight into the ways people experience certain events and assist in gaining a rich understanding of a phenomenon within a certain social context. In contrast with quantitative methods where the analytical focus is on quantifying variations and making predictions of casual relationships, a qualitative methodology focuses primarily on describing variations, relationships and individual experiences. It is therefore highly appropriate for the purposes of this study.

A qualitative design involves amongst others, uncovering the nature of power relationships within a setting, while it seeks through its enquiry to raise consciousness about existing norms associated with certain groups. At this point, it is important to reflect on the usefulness of this approach when conducting research with vulnerable populations. The views and stories of socially excluded groups do not often feature in analysis and this may lead to development of false assumptions. In contrast, the prime aim of a qualitative design is to give voice to lived experience of a socially excluded group. The flexibility and openness of a qualitative design provides both space for recognition of participants as experts of their circumstances and assists in articulating not merely the similarities but also the differences between members' experiences and perspectives. In this realm, the qualitative enquiry was used to uncover and understand the perspectives and insights of socially excluded populations, enabling them to express and articulate their realities as they are without disrupting the process. Rather, *"a respect for and curiosity about what people say, and a systematic effort to really hear and understand what people tell you"* (Rubin & Rubin, 1995, p. 17) was emphasized.

At first stage, a hypothesis that the principles of attachment theory may be useful in giving an insight in participants' behaviour was considered. However, the aim was not to test this hypothesis, but rather to use the theory as a framework and allow the data to build the arguments. In this respect, the iterative and flexible elements of qualitative analysis was deemed particularly helpful in the elucidation of relationships between concepts, while also assisted in *"generating the kinds of linkages that will form the basis for the development of theory"* (Bryman & Burgess, 1994, p. 7). The data collection methods aimed to describe the complex construct of attachment experience and identify structures and interactions between mechanisms and social actors.

Generation of concepts entailed immersing oneself in the data, searching for patterns and being sensitive to inconsistencies. However, whilst primarily qualitative in orientation, the study did contain an element of quantitative investigation. For, prior to in-depth qualitative interview analysis, a *quantitative translation* of interviews with people with experience of MEH (referring to the Attachment Style Interview, see next section for a detailed account) was conducted. This translation allowed for qualitative data to be transformed into categories for discerning attachment styles and measuring the extent to which each participant exhibited the characteristics of each category. Analysis allowed for identification of descriptive categories (participants' attachment styles) and the process was repeated for identification of conceptual themes.

The rationale for using a standardised interview measure was grounded in the fact that purely qualitative methods were insufficient for discerning current patterns of attachment. In addition, in certain circumstances the reduction of qualitative data to categories *"can sharpen the focus of the key findings' and/or add a form of convergent validity"* (Sandelowski, 2001, p. 233). In other words, this process of converging qualitative data to categorical variables (attachment styles) allowed for the discernment of (ir)regularities that previously were not visible within existing data (see Sandelowski et al., 2009). The quantitative findings represented the attachment concept in classification terms. On the other hand, qualitative interviewing explored the intricacies of the same concept by giving depth and nuance to the data (Nelson & Prilleltensky, 2010). Identification of attachment patterns combined with a qualitative analysis of narratives emerging from the same interview further enabled the verification of both the procedural and analytic aspects of the attachment experience of participants. This combination of methodological practices may be best conceptualised as *"a strategy that adds rigor, breadth, complexity, richness, and depth to any inquiry"* (Flick, 2002, p. 229).

The challenge lay in avoiding the decontextualization of categorical variables. In qualitative research, context is highly relevant and contextualization of all type of findings is essential for understating the underlying processes and validating any inferences. Through the analysis process, particularly emphasis was given in exploring the unique meanings that participants assigned to certain attachment experiences but also to engage with attachment theory through the process of quantitative classification. In other words, the data collection methods fed back and complemented each other.

In CR, qualitative data and forms of quantitative findings may often be combined and integrated in the identification of tendencies and causal mechanisms (Zachariadis et al., 2013). The choice of data collection procedures may also depend on the extent to which

each method complements and engages with existing theories, and most importantly the degree to which it is able to identify generative mechanisms and causal links (Zachariadis et al., 2013). This methodological pluralism includes a degree of 'epistemological relativism' that as a matter of fact signifies that some forms of knowledge might be more accurate and valid than others, at least to a certain degree. Eisenhart (1989) asserts that the combination of methods can *"provide a stronger substantiation of constructs and hypothesis"* and explain that *"these constant comparisons serve the purpose of identifying and developing new theory than testing and developing hypothesis from prior research"* (as cited in Elsbach et al., 2015, p. 539). It was envisaged that this process of complementarity could maximise potential for further elucidating the intricacies of attachment experience in those that have experience of MEH.

4.2.2 Realism as a stance for qualitative research

Besides acknowledging the significance of participants' voice beyond standardised methods and statistics, qualitative research seeks to examine deeper causal processes and explanations. Similarly, CR is primarily focused on understanding and conceptualising a certain phenomenon, rather than just describing it. It denies the existence of a single correct understanding of the social world and attempts to capture some of the unique social relations evident within a certain context. In this section the main analytic strategies for applying a realist perceptive to aspects of qualitative research will be carefully considered.

Maxwell identified four reasons for highlighting the importance of a CR strand in defending qualitative research (Maxwell et al., 2011). He argued that CR's main principles correspond closely to key goals of qualitative research by: incorporating causal explanations, examining mental concepts as being real entities, emphasizing the relationship between actors' perspectives and their actual situations, and understanding diversity as a real phenomenon. The in depth analysis that qualitative methodology offers the examination of causal relationships by constructing a potential mechanism for explaining relations. In this respect, according to Roberts (2014), CR develops a 'quality theory of causality' by attempting to make sense of the unique social relations as they emerge.

A key feature of CR is that it supports the validity of the conception of causality. The focus of qualitative researchers on causal explanations even in individual cases without using comparison or control groups is crucial in this respect (Shadish et al., 2002). The aim is to capture some of the unique social relations within context and gain an insight into how individuals may feel, think or behave by encouraging open discussions. By being

reflective and open, by probing in more depth and allowing participants to openly discuss their experiences, casual processes can be directly observed. Additionally, the significance of contextual information in understanding social phenomenon in qualitative methodology is further assisting in developing potential mechanisms that explain what makes things happen in specific cases (Sayer, 2002). Pre-established comparisons and universal laws are under question when considering that "*the context within which a causal process occurs, is intrinsically involved in the process"* (Maxwell, 2004 p. 7) and that *"causality is inherently local rather than general"* (Tashakkori & Teddlie, 2010, p. 159).

In qualitative critical realism research, emphasis is placed on allowing new data to emerge by "*recognizing the conditional nature of all its results"* and avoiding any commitment to preconceived ideas (Bashkar, 1979, p. 6). All explanations of reality are considered to be potentially fallible and a great amount of flexibility and openness to new, emergent ideas is granted. Participants' perspectives can challenge and question previous ideas and knowledge and potentially formulate a more accurate explanation of reality. In this equation, emotions, beliefs and values are all considered part of reality and not seen as distinct elements. In other words, mental concepts are considered to be real entities. Maxwell et al. (2011) argued that it is plausible for reasons to be seen as real events leading to action. In this realm, qualitative researchers acknowledge the significance of internal processes and mental events in explaining any social phenomena and on many occasions 'reason explanations' are seen as causes. Put another way, when attempting to produce explanations about certain properties, it is fundamental to understand and interpret the *meaning* and *processes* by which an event occurs. The need for interpretation and understanding of individuals' actions is quite significant in CR. Similarly, in qualitative social research, the examination of the relationship between an actor's perspectives and actual events is absolutely necessary for a richer conceptualization of the internal mechanisms at hand.

This study follows the CR paradigm, in seeking to *"uncover alternative characteristics of the same layered reality"* (Zachariadis et al., 2013, p. 12). It is founded upon the assumption that there is a need for a deeper examination and a more accurate explanation of the casual connections between individual factors and causation of MEH which could potentially inform and transform current service practices and policies. In doing so it is critical to think conceptually about how certain casual mechanisms may operate. The study uses the theory of attachment to initially explain what makes things happen in specific cases, or more specifically what is about certain individuals that may find themselves experiencing MEH for prolonged periods of time? In CR, theory is used

to help hypothesise about certain mechanisms at play and provide explanations for the events that have occurred (Zachariadis et al., 2013). Similarly, in qualitative research a theoretical explanation is developed with the aim of empirical data. Its purpose is to assist in explaining and describing events and structures rather than theory-testing.

4.3 Data Collection

This section describes the process and methods involved in the study's data collection. It begins by providing an account of the selection of the case study agencies in which participants were recruited. This is followed by detailed description and justification of the methods and sampling strategies used to collect data from: firstly, service users, and secondly, staff members. An overview of the key methods, their analytic focus, and relationship to specific research questions is provided in Table 4.1.

METHOD	CONTRIBUTION	ANALYTIC FOCUS	RELEVANT RESEARCH QUESTIONS
1. Service user **Attachment Style Interview (ASI)**	- Standardised measure - Captures participants' perceptions of empirical reality - Moving between surface appearances and depth reality	**i)** Identify the attachment style of participants **ii)** Assess the degree of insecurity (mild, moderate, marked) **iii)** Assess capacity to develop supportive relationships **iv)** Assess ability to access support in times of need	Research question 1 Research question 2

2. Service user qualitative interviews (ASI is supplemented by additional questions)	- Empirical and actual experiences related to formed attachments. - Expansion of data beyond a descriptive account; emphasis on the underlying mechanisms - Looks at events which have been generated by structures	**i)** Describe how attachment experiences impact the relationship with support services **ii)** Consider the impact of attachment on the pathway into MEH **iii)** Explore participants' views on services	Research question 2 Research question 3
3. Staff Focus Group	- Actual and Empirical experiences of staff members when supporting MEH populations	**i)** Describe the cognitive and emotional responses of staff members towards service users **ii)** Explore the beliefs and approaches underpinning current practices	Research question 4

Table 4.1. Mapping of research questions to data collection methods and analytic focus

4.3.1 Selection of case study agencies

The first stage of data collection required the selection of case study agencies that support people who have experienced of MEH. Four homelessness services located in two Scottish cities, Glasgow and Edinburgh, were involved. A number of service users and staff members were purposively sampled within these and invited to participate in the study (see below for details of the sampling and recruitment procedures used). Although the number of sampled services was relatively small, they were chosen to be typical services

that work with MEH populations in Scotland. The focus was on drop in and outreach services that engage with marginalized populations. The aim was to recruit services that place a similarly low level of behavioural demands on users, offer similar types of support/case work, and target the same client group.

In this vein, the case study agencies fulfilled three broad criteria, these being that they: (1) aimed to support vulnerable and disadvantaged people out of homelessness, (2) offered ongoing support, and (3) operated a drop in service and/or a street outreach service or both. The focus was on 'low threshold' services due their openness regarding service user eligibility criteria and low expectations as regards user 'engagement'. These relatively low demands on clients increases the likelihood that they will be in contact with the most vulnerable members of the population of interest (Fitzpatrick et al., 2013). In acknowledgement of the complex needs and multiple forms of exclusion that those individuals are faced with, those services focus on both offering assistance while in crisis but also provide support for addressing the overlapping reasons underpinning homelessness.

The set of principles for selecting the case study agencies aimed to achieve a certain degree of representativeness, insofar as is possible in a study of this scale and minimise biases related to recruiting participants through only one agency. The cases were carefully selected to be similar to each other (in terms of characteristics, ethos, aims and targeted client group). As opposed to producing contrasting cases, selecting case study agencies that make similar demands from clients can provide insights into the phenomenon understudy by obtaining similar data which can offer depth and validity to findings.

4.3.2 Service user interviews

A major component of the study constituted a set of interviews with 30 service users. The aim was to gain a deeper understanding of participants' experiences, allow their stories and realities to emerge, and look into the prevalence of attachment styles within the studied population. These interviews were key to answering the following research questions: 'What are the attachment styles exhibited by individuals that have experience of MEH?' 'What influence, if any, do attachment experiences have on their pathway into MEH?' and 'What is their relationship with support like?'.

A purposive sampling approach was chosen to facilitate contact with participants that may be regarded as 'hard to reach'. In order to be eligible to participate, service users had to be 18 or older, willing to take part in the study and meet certain pre-determined criteria as regarding experience of MEH. In particular, recruitment of participants was

based on a pre-existing sample frame used in the Fitzpatrick et al. (2013) study of MEH. Hence, service users were invited to participate in the study if they had been homeless (including experience of temporary/unsuitable accommodation as well as sleeping rough) and had also experienced one or more of a number of other 'domains' of deep social exclusion, these being: 'institutional care' (prison, local authority care, mental health hospitals or wards); 'substance misuse' (drug, alcohol, solvent or gas misuse); or participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work) (Fitzpatrick et al., 2013, p. 149). Given the duration and intensity of the qualitative interviewing, participants were selected with the assistance of staff members.

As far as sample size was concerned, previous evidence suggested that sample sizes for both correlational and causal-comparative studies should be determined based on data and theoretical saturation (Gall et al., 1996; Creswell& Miller, 2002; Bryman, 2012). That is to say that an adequate number of interviews is achieved when repetitive patterns emerge and no new information is generated (Guest, 2006). Alternatively, the goal is achieved when there is enough information to replicate the study (Walker, 2012). Nonetheless indicative numbers of sample sizes of most common research designs do exist. For instance, a (minimum) number of participants for a phenomenological study may be 36 whilst a case study may just have around five participants (Creswell & Miller, 2002). In the present study, a minimum sample size of 30 service users was selected. The number was determined based on the numbers of interviews that may be adequate to inform fully all elements of the study and address the research questions under investigation. Furthermore, the depth of interviews and the vulnerability of sample participants was also taken into consideration.

The appropriateness of the interview measure and its applicability to the MEH populations were assessed by conducting three pilot interviews with service users, analysing the findings, asking for feedback from participants and adjusting the phrasing and order of the questions accordingly. Those interviews were not included in the total of 30. Interviews with service users lasted an average of 75 minutes, ranging anywhere from an hour and fifteen minutes to an hour and half. A comfort break of ten to fifteen minutes was offered to all participants. As a gesture of thanks for their time service users were given a £20 shopping voucher. All interviews were audio recorded with participants' permission and transcribed verbatim. In order for participants to feel comfortable and assured, all interviews were conducted in the premises of the homelessness service through which participants had been sampled and at a time convenient to them.

The service users' interviews comprised three main components: collection of basic detail regarding demographic characteristics and adverse childhood experiences; the Attachment Style Interview (ASI); and a qualitative interview which focused on participants' relationship with support services and explored the influence of attachment experience on their pathway into MEH. Each is discussed in more detail below.

4.3.3 Demographic and Other Descriptive Data

Basic questions regarding each service user's demographic characteristics (see Appendix A), current circumstances (e.g. housing/homelessness status) and experiences related to each of the domain of MEH (e.g. experiences of institutional care) were asked of all participants prior to interviewing. Additionally, the Adverse Childhood Experience (ACE) questionnaire (see Appendix B) was completed. Findings assisted in examining ACEs in rather a simple casual manner, as no severity, timing and duration of the potential adverse experiences were measured. These data were used to provide invaluable contextual information which was used to facilitate the interpretation of data from the other tools used, as described below.

4.3.4 Attachment Style Interview (ASI)

Identification of participants' attachment styles was pivotal to the study. To address this aim, the ASI was used. The ASI was chosen after an extensive review of existing attachment measures (see Appendix C) and undergoing training in its administration. The interview addresses both study requirements aiming to assess the attachment styles of service users but also generate descriptive data on strategies and motives that underpin their behaviour when seeking support. Its style is conversational and it oscillates between directive and non-directive interview questions, which allows researchers to fully adapt to the respondent's style. Those characteristics were also deemed essential in opting for this measure given the high vulnerability and unique traits characterising MEH populations.

In detail, the ASI is an investigator-based, semi-structured interview that was developed by Bifulco and colleagues (2002) to assess current attachment styles (see interview plan on Appendix D). The interview identifies the attachment style based on an interviewee's ability to make and maintain relationships and access and utilise social support. It provides a categorisation of the attachment style of individuals, as well as assesses their specific support context and quality of close relationships (Bifulco et al., 2008). Simultaneously, it assesses the degree or severity of insecurity as either *mild, moderate* or *marked*. It is the only measure that includes a behavioural assessment and

when compared to other assessment tools, ASI does not solely provide quantified information on an individuals' overall attachment style but also gives descriptive information about the particular individual in his/her relationships. It also encompasses a brief Recent Life Event Questionnaire (RLEQ, see Appendix E) (Burgha & Cragg, 1990) that has been previously used to examine the level of psychosocial risks for mental health problems (see Bifulco et al., 2002). The purpose of including a checklist of events according to Bifulco et al. (2013, p. 34) is:

> …not only to place the ASI in line with a stress model (where the purpose of close attachments is to provide support at times of crises) but also a more pragmatic function of outlining recent severe events in order to aid confiding questions, and grounding these in actual recent examples.

In other words, the brief checklist was introduced as a list that covers a number of events that may have happened to interviewees over the last one to two years and still affects their life. While the ASI was taking place, the events that were confirmed in the list were used for enquiring whether the interviewee confided about those events in the support (partner or VCO) section. The purpose was to assist the interviewees recall important life events and in parallel assist the interviewer to enquire whether support was offered during those times of need from important others. For the purposes of the study, the questionnaire was adjusted to fit the population under study. For instance, pilot interviews indicated that questions such as 'Have you or your partner been unemployed or seeking work for more than a month?' or 'Have you moved house through choice?' were not relevant to participants. Those questions were removed and were used only as prompts when appeared to be relevant (for instance when participants were in temporary accommodation).

As previously mentioned, the interview primarily assessed the extent to which participants do or do not exhibit the characteristics of five attachment styles. In particular, the developed attachment styles correspond to secure, avoidant (angry-dismissive or withdrawn) and anxious (enmeshed or fearful) dimensions. The classification of those attachment dimensions is common to most attachment instruments. However, ASI is the only measure that differentiates and identifies an angry-dismissive style. It also allows for classification of a dual/ disorganised style when no single attachment pattern emerges. In

those cases, elements of more than one style are present and the more pervasive style (primary) may co-exist with one or more (subsidiary) attachment styles.[3]

ASI questions elicit information on the quality of close relationships based on a set of attachment attitudes: the degree of confiding to others; the ability to actively seeking emotional support when in need; any positive and negative interactions with important others; and the felt attachment in current relationships (see Appendix D part one). Additionally, it assesses seven attitudinal scales related to global aspects of attachment., these being: mistrust, constraints on closeness, fear of rejection, fear of separation, anger, high desire for company and self-reliance (see Appendix D part two). Those scales have been shown to be robust in retrospective use and they can be also studied individually in relation to psychopathology (Bifulco et al., 1998, 2004, 2009).

The ASI was analysed quantitatively based on predetermined benchmarks and rules, which have been developed by Bifulco and colleagues (1998) to ensure consistency.

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[3] Methodologically, the term 'disorganised attachment' is applied to adult respondents who show more than one salient profile on Attachment Style Interview (see Bifulco et al., 2016). According to Bifulco et al. (2012) this combination of styles is equated with a dual/disorganised attachment style. Drawing upon existing attachment literature and conducting some case analysis, Bifulco et al. argued that a dual rating may reflect some earlier 'unresolved loss or trauma', but no substantive links with Main and Solomon's (1990) initial construct of 'disorganised attachment' are suggested based on current findings. Main and Solomon (1990, p. 133) defined disorganisation, specifically, as "an observed contradiction in movement pattern, corresponding to an inferred contradiction in intention or plan". The developmental literature suggests that disorganization in infancy is predictive of behaviours in childhood, adolescence, and early adulthood. Additionally, a category known as "unresolved," as measured on the Adult Attachment Interview (the AAI, a developmental attachment measure; Main, Kaplan, & Cassidy, 1985; George, Kaplan, & Main, 1985) was designed to correspond conceptually to the disorganized attachment category as seen in the Strange Situation (Madigan et al., 2006; van Ijzendoorn, 1995). Nevertheless, the term 'disorganised' has been extended to attachment assessments of older children and adolescents, sometimes used as a general and diffuse term for attachment pathology and incoherence with few substantive links with Main and Solomon's infant construct. For instance, Mikulincer and Shaver (2007), as well as other researchers in the field (see Simpson & Rholes, 2002), have argued that disorganization may be a particular form of avoidance known as fearful avoidance. People seen as fearful avoidant are believed to have a mixed attachment strategy, one that is high on both the anxiety and avoidance dimensions used today by social psychologists. Similarly, disorganization is seen by Paetzold et al. (2015) as distinct from a mixture of organized attachment strategies because it involves fear of the attachment figure as a person, something that neither attachment anxiety nor avoidance include.

Key comments were rated following specified scoring scales on the basis of prior training. In parallel to the investigator-based aspect, ASI has also a semi-structured side. It provides flexibility in questioning and probing in relation to particular themes that are relevant to the interviewees. Additional probes can be used to encourage participants to elaborate as and when required. Its conversational style also allows for qualitative analysis to occur as per the specific interests of a study. The ASI takes up to 60-70 minutes to implement (although this may vary) and it is necessary to audio-record it. Analysis and scoring takes up to two hours per interview. Training in its application, run by the Centre for Abuse and Trauma Studies in Middlesex University, was completed prior to development of the research instruments and fieldwork.

4.3.5 Validity and limitations of the ASI

Previous research with vulnerable populations, such as with children in foster care (Bifulco et al., 2008) and adults with mental health issues (Bifulco et al., 2002; Bifulco et al., 2004; Sheinabum, 2015) have shown that the ASI is a flexible and a context-sensitive assessment tool. ASI's amenability to quantitative analysis quality has indicated that it is a reliable and well-validated tool for use in 'assessing supportive context' for vulnerable populations (Bifulco et al., 2008). In particular, ASI has demonstrated good convergent validity with self-report measures of adult attachment and good predictive validity for the development of psychopathology, in relation to depression and anxiety disorders in both adults and high-risk adolescents (Bifulco et al., 2002; Oskis et al., 2011; Schimmenti et al., 2015). Previous research has also shown a significant association between high levels of some insecure attachment styles (when moderate and marked) and adverse childhood experiences, such as neglect and psychical/sexual abuse (Bifulco et al., 2006). From a practical standpoint, ASI can be effectively interpreted in social care contexts and make the research findings easier to understand for practitioners (Bifulco et al., 2008). This holds potential for enabling staff members to be more confident and assured in assessing and meeting the attachment needs of individuals that they support, including those with the most complex needs.

As is true of every attachment tool, the ASI comes with certain limitations. Although it has been increasingly used in fostering and adoption services, further research is needed to show support for its role in assessing attachment in vulnerable populations that experience complex needs. Moreover, the attachment styles identified via the ASI are based solely on the information and evidence that is provided by participants. For instance, in the Adult Attachment Interview (AAI) participant's narrating styles, pauses and general

non-verbal communication are a crucial part of the analysis. Relevant research has indicated that the exploration of the internalised attachment constructs through facial and body expressions could add validity to the data by providing useful insights into participant's attachment security (Hesse, 2008). In contrast the ASI was originated through evidence-based research and was remarked for its predictive properties in mental health and fostering context. In addition, the ASI is considered to be a labour-intense and time-consuming method, in that training in its use is required and scoring and analysis of each interview takes up to two and a half hours. The assessment time required is an important factor to be considered, especially when compared to most self-report measures that do not require more than 30 minutes for administration, scoring.

Nonetheless, the existing evidence support the notion that the application of an objective and standardised measure in adult services, such as the ASI, can hold potential for improving current practices. Its implementation in the assessment procedure of services can provide important information on the relating patterns of service users and somewhat 'predict' and inform how best to facilitate a supportive relationship in a personalised fashion. Among others, the purpose of this study lies in addressing the practical implications of using an attachment framework to facilitate positive relationships and increase levels of engagement. Therefore, the ASI was deemed as the most appropriate tool for capturing the attachment styles of service users that have experience MEH.

4.3.6 Qualitative follow-on interview

The final component of the service users' interviews allowed for in-depth exploration of the experiences of MEH populations in/when engaging with support services and reviewed the potential influence of attachment predispositions on the causation of MEH. The ASI interview plan was therefore followed by a series of semi-structured, open-ended questions which were analysed qualitatively (see Appendix F). All participants were asked the same set of semi-structured questions (e.g. 'How did you become homeless at the first instance?' or 'Which services have you used over the last two years?'). A set of probing questions was also used for eliciting further descriptions about the respondents' particular experiences.

In sum, the purpose of utilising a qualitative research design was to gain a deeper understanding of participants' experiences and allow their stories to be heard. The aim was to *"to shift through the narrative responses in order to fully and accurately reflect an overall perspective of all interview responses through the coding process"* (Turner, 2010, p. 756). The brief, open-ended interview provided enough space to participants to express

their viewpoints and give as much depth and detail as they felt comfortable with (Gall, Gall, & Borg, 2003). It further allowed the researcher to draw a number of inferences. This qualitative enquiry was seen as a tool for generating rich data and allowed research to focus on the interactions and constructions that social actors make (Brekhus et al., 2005).

4.3.7 Staff focus groups

The final component of this study constituted a set of four focus groups with front-line staff members recruited from the four case study agencies (see above). These were utilised to help answer research question four, that is, 'What are the cognitive and emotional responses of the staff members towards service users with insecure attachments?'. Focus groups were deemed to offer the greatest potential to give insight into how staff members make sense of the so-called 'chaotic' and challenging behaviours that a number of service users may exhibit when seeking and engaging with support. It was envisaged that the focus group approach and its interactive processes could highlight how staff members built up their views and perspectives, uncover potentially hidden factors that may influence behaviour in a collective manner, and allow for unexpected aspects that have been taken for granted to be pointed out.

Staff focus group participants were sampled purposively. Aiming to facilitate comparisons amongst groups, participants were recruited on the basis of homogeneity in regards to their job title (support workers or support practitioners). Overall criteria for participation were: (1) their role involved regular direct interaction with people experiencing MEH and (2) they had at least one-year prior experience of working with this client group. In practice, the kind of tasks that such individuals were involved in included a combination of any of the following: case management planning, crisis intervention, signposting, provision of guidance and advice on housing, employment and training options, advocacy and assistance with healthcare and rehabilitation. In order for discussions to have a flow and be as natural as possible, natural grouping procedures within each professional setting were followed. That is to say, focus groups took place in the ordinary settings where people work, while most participants were members of the same team. It has been argued that the comfort and familiarity that pre-existing groups have already developed, may counteract difficulties in expressing openly within a group setting (Krueger et al., 2015).

It was initially envisaged that focus groups would consist of six to eight participants, but the nature of frontline work in these types of services and the imperative of ensuring that staff coverage 'on the floor' was not compromised, meant that it was not always

possible to do so. Overall, one group had five participants, one had six participants, and the remaining two focus group involved four staff members. Focus groups took place in a private office within each service, although flexibility in regards to location was ensured to encourage participation. All sessions were audio-recorded with participants' permission and transcribed verbatim.

Focus groups were administered in a semi-structured way. Vignettes were used to bring a certain degree of focus and structure to the conversation. Vignettes were hypothetical but realistic cases or scenarios and are widely used in social sciences to prompt responses to interview questions. They are proven to be a useful tool for providing a clear focus and stimulus for group discussions (Sim et al., 1998; Hughes, 2001). In detail, they offer a complementary technique which is less personal, yet thought-provoking and offers the possibility to explore practices and strategies in context. Hughes (2001, p. 161-163) used vignettes to evaluate the judgements and decision making processes of health care professionals and argued that vignette based methodologies *"can simulate certain aspects of real-world scenarios…while overcoming the ethical, practical, and scientific limitations associated with alternative methods"*. It was envisaged that the provision of vignettes along with the ongoing interactions that take place in a focus group would allow members to reflect and compare strategies and practices, as well as re-examine the reasons behind certain approaches.

In practical terms, the construction of the vignettes was informed by a combination of the existing literature and previous research (Bifulco et al., 2002; 2008; 2012) and the researcher's professional experiences in the homeless sector. The researcher drew heavily upon existing literature to develop each of the scenarios presented. Further to this, having previously worked in the sector assisted in carefully considering the nature of potential participants and developing the vignettes accordingly. Internal validity was checked by sharing and discussing those vignettes with an expert psychologist in the homelessness field in order to assure that the vignettes were as realistic as possible. The expert had sufficient knowledge and experience to judge their suitability for the study and acted as an external supervisor throughout the study.

More specifically, key previous research findings relating to five distinct attachment styles in adulthood (see Bifulco et al., 2013) were used to construct the scenarios such that each outlined a case exhibiting behaviours typically associated with a different attachment style, these being: enmeshed, fearful, withdrawn, and angry dismissive (see Appendix G). Each attachment style has a characteristic trait that was emphasized in the scenario. The fearful style is primarily characterised by a fear of rejection, the

enmeshed style by a fear of separation, the angry-dismissive style by increased anger and frustration, and the withdrawn style by high self-reliance and high constraints on closeness (Bifulco et al., 2012). A vignette for a secure attachment style was not included based on the focus of the study on challenging and difficult behaviours. All constructed cases were characterised by high insecurity (marked ability to make and maintain relationships) to vividly reflect the reality of people's lives when in crisis. Little emphasis was placed on eccentric scenarios or vignettes depicting characters that were able to engage with services effectively.

Vignettes were administered to all focus group participants in a plainly written form on a laminated card and described verbally. Participants were then asked a series of questions to prompt discussion (see Appendix H) regarding how would they react to and feel about the individual, and why the cases depicted (and others like them) may behave in those ways. In detail, the following four questions were used: 1. *What is your understanding about the ways in which this person relates to the services described?* 2. *How would you engage or interact with them and why?* 3. *What do you think would be the major challenges for you as someone trying to work with this service user? 4. How do you think this sort of behaviour might make you feel?* Overall, a flexible approach was adopted when encouraging participants to respond. It is notable that all staff members commented that situations and characters presented in vignettes appeared realistic in that they felt that they already 'knew' the person described. This finding further confirms the internal validity of the vignettes, given the aim for those scenarios to be as realistic as possible.

With regards to timing, a new vignette was given to focus group participants every 15-20 minutes and the same process (initially reflecting freely and then prompting with questions) was followed for each scenario. Participants were made aware in the beginning that they will be discussing four vignettes and the process will take about an hour and 15 minutes. However, no strict time restrictions were imposed upon them to respond to vignettes and adequate time was given to reflect and answer the questions. For instance, when participants were involved in a lively discussion for more than 15 minutes, the researcher did not introduce a new vignette. New stimulus, either in the form of a new vignette or a question, was introduced when there was a pause in the discussion.

Overall, although the focus group is a methodological approach that is often seen as a relatively easy way of gathering a large number of views on a topic in a short period of time, it does come with certain difficulties. For instance, the dynamics that may emerge may not always allow everyone to express their view or discuss the topic in as much detail as they may wish to. Furthermore, not all members may be motivated to reflect upon the

topic, whilst others might be more inclined to agree with the shared view of the majority rather than expressing their own views (Krueger et al., 2015). The fact that it is a relatively unstructured approach, in which the facilitator is intervening as little as possible, can be limiting the discussion to some only aspects of the phenomenon under study (Acocella, 2012). In overcoming those barriers, the use of the vignettes and some additional probing questions assisted in developing a synergy between members which encouraged them to reflect, discuss, and at times challenge one another over certain ideas and perspectives.

4.4 Data Analysis

This study adopted Braun and Clarkes' procedural model of thematic analysis for both interviews and focus groups. In line with a critical realist approach, emphasis was given both to the exploration of subjective experience of participants and the underlying processes and mechanisms which constitute a multi-layered social reality. Braun and Clarke (2006) identified similarities between a realist method and the analytic technique of thematic analysis, which has been conceptualised as a method for reporting experiences, meanings and the reality of participants. They argue that *"thematic analysis can be a method which works both to reflect reality, and to unpick or unravel the surface of reality"* (Braun et al., 2006, p. 9). Similar to the CR approach, in thematic analysis the researcher can identify theoretically derived themes which may replicate, extend or reject previous research findings but remains open to new ideas and concepts as they emerge (Boyatsis, 1998). Braun and Clarke's framework for doing a thematic analysis identifies six phases. Those stages being: familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and finally naming/writing-up themes. The application of each of these is described below, before reflections regarding the contribution of CR to the analytic process are shared.

4.4.1 Steps of analysis

The first step necessitated reading and re-reading the transcripts, making notes and writing down early impressions. Prior to generating initial codes and moving forward with analysis of the data, careful consideration was given to the question 'what counts as a theme?'. In this vein, thematic analysis was driven by each particular analytic question of the study, and identification of themes was based both on prevalence and significance across the data set. In detail, themes were considered to be important when there were a number of instances that appeared within the data set (prevalence in terms of space within each data set and across all sets), but also in terms of whether they captured something

important in relation to the overall research questions. A degree of flexibility was employed during this process, aiming also to achieve a rich description of the entire data set rather than just the detailed account of a particular aspect. This process of data engagement was considered to be a useful method considering that attachment experience and MEH is an under-researched area and participants' views and experiences were not previously known.

The analysis was primarily driven by theoretical and analytic interest in the area, and a number of themes were developed around attachment experience. Because no other studies have looked into the influence of attachment experience on MEH causation and the support seeking process of people experiencing MEH, a flexible and reflexive approach to coding was deemed appropriate. The coding frame drew on existing theory and literature but was also strongly informed by themes emerging from the interview and focus group data. In this sense, coding was understood as an active and reflexive process rather than a search for evidence of themes, or an attempt to prove or disapprove a hypothesis or test a theory.

In this realm, emphasis was placed in identifying conceptual themes based on the narratives of participants and looking beyond the *semantic* content of the data. This refers to the underlying ideas, assumptions and conceptualizations that informed the semantic context of the data. This step of 'going beyond' the content of transcripts contained a strong element of interpretation which was based on the researcher's judgement and was guided by the specific research questions and the chosen theoretical framework. This semantic and conceptual reading of data corresponds with a CR perspective in which the focus is not merely on the explicit recording of themes but also on discerning regularities for the description of more abstract and analytic themes. In this light, emphasis was given both to the exploration of subjective experience of participants and the underlying processes and mechanisms which constituted the multi-layered social reality.

Upon familiarization with data and initial coding (both through transcribing and reading through the data set multiple times), the large number of codes were gradually reduced during the second coding cycle and reorganised. During this stage occasionally new codes were generated, while others were modified. This was done manually, working though hard copies of the transcripts, taking notes and coding every segment of text that was relevant to or addressed the research questions. Discussions with the main supervisors of the study about coding stages and preliminary ideas assisted in forming provisional coding schemes and themes. The analysis followed a *recursive process* with movement back and forth between the entire data set, coded extracts and different phrases and topics.

This entailed organising the data into meaningful groups. This involved searching across a data set (i.e. a number of interviews) and its codes to find repeated patterns of meaning. For instance, there were several codes referring to a diminished sense of self-worth and shame that related to a general negative view of self and a cycle of hopelessness amongst participants. Those were collated into an initial theme called 'the portrayal of self' (see chapter 7).

After all data were coded and collated, the next stages were concerned with searching for and reviewing themes. A brief thematic map with potential topics was created which assisted in thinking about the relationship between codes and between themes. The map was created in relation to the research questions of the project and facilitated the development of potential sub-themes. When a sense of the significance of individual themes was obtained, analysis then moved to the phase of refinement and review of those themes. This process assisted in considering the validity of each theme in relation to the data set and coding any themes that had been missed in earlier stages. This was an ongoing process and sub-themes were revised repeatedly. The next phases were concerned with defining and naming themes and analysing the data within them.

As previously noted, analysis stages were partly guided by the paradigm of critical realism. Although the lack of literature on applied CR created a challenge, aspects of CR were applied to data processing. In particular, CR guided what was said about the data and informed how its meaning was theorized. This refers to *"a rolling process of both; constant posing of questions to material and also applying different forms of comparisons for understanding in depth the social phenomenon under study"* (Danermark, 2002, p. 133). In keeping with CR ontology, a brief overview of the data processing phases as they have been theorised by Zachariadis follows.

4.4.2 Data analysis and CR

Zachariadis (2013) identifies four broad phases for data analysis; (1) the description or appreciation phase, (2) the retroductive analysis of data, (3) the critical assessment or elimination of alternative explanations, and (4) action for circulating findings. The initial phase refers to the selection of relevant theoretical components that were examined and informed the study. A key element of this stage is to identify concepts within existing literature that can assist in explaining the phenomena under scrutiny. According to Fletcher (2016, p. 188), the abduction process *"raises the level of theoretical beyond thick description of the empirical entities, but with an acknowledgement that the chosen theory may be fallible"*. For instance, the low levels of engagement of service users may easily

be attributed solely to addiction issues or mental health problems which often coincide with homelessness. The question here is whether it is possible to explain the difficulty to engage and maintain connection with support solely as a consequence of poor mental health and drug and alcohol misuse?

In explaining associations, a critical realist may criticize this approach as lacking profound insights into aspects of social behaviour or that the causal link identified is just one strand of the phenomenon under scrutiny. Although these associations are important and may often be reflected in participants' narratives, it is crucial for critical realists to go beyond these explanations and consider deeper causal connections within context (Fletcher, 2016). In this case, Sayer (2000, p. 17) argues that there is a need to *"distinguish what must be the case from what merely can be the case"*. Explanation of the social world also requires an attentiveness to its stratification, to emergent powers arising from certain relationships, and to the ways in which the operation of causal mechanisms depends on the constraining and enabling effects of contexts.

The next stage of analysis is concerned with the retroductive analysis of data. This mode of inference is aiming to name the possible mechanisms that cause the phenomenon observed (Zachariadis, 2013). It requires moving from the abstract to concrete and back again for identifying *"necessary contextual conditions"* (Fletcher, 2016, p. 189). Looking at the theory that informs the study, current hypothesis and emerging data, the researcher enquires about the necessary conditions that cause the particular phenomenon to emerge. In a sense, the descriptive accounts of participants acted only as a starting point for uncovering the hidden dimensions of social reality. For example, attachment trauma is a key causal mechanism driving individuals in losing their sense of control and increasing participants' vulnerability and ability to cope with stress, even though number of participants directly identified attachment trauma as a causal factor for homelessness.

The next stage of interpretation and extension of data necessitated a critical assessment of how a number of mechanisms interact and shape social reality. That is to say that the researcher aims to provide a fuller interpretation of reality and ultimately attempts to modify, support or reject existing theories (Fletcher, 2016). As analysis progressed, the final stages necessitated capturing the essence of identified themes or regularities and conducting a detailed analysis of each of them. For a critical realist this writing up phase encompass some sort of action for the *"development of programs of change appropriate to the situation and based on responses"* (Zachariadis, 2016, p. 12). For instance, this research project produced a number of recommendations for improving service delivery by identifying causal mechanisms and looking into participants'

behavioural tendencies. Those recommendations can be particularly useful for improving current practices and staff's training.

At a last note, it is worth considering that this analytic schema is best conceptualised when grounded within the social conditions and ideological/structural context that participants live and act within. For, when historical or cultural contexts are overlooked, findings tend to be misleading (Zachariadis, 2013). The role of contextual factors in the lives of MEH populations, such as poverty, lack of affordable housing or poor mental and physical health (just to name a few), combined with the welfare and housing reform agenda severely interplay and shape homelessness in the UK. For critical realist agents' behaviour is not an independent social phenomenon, but rather contextual in its realization. It was thus assumed that *"in the case of the discourses of social agents, it is necessary to be sensitive to developments within the ideological environment which maybe determinant in the practices of those agents under investigation"* (Crinson, 2001, p. 11). For these reasons, broader contextual factors were taken into consideration throughout the analysis process.

4.5 Ethical Considerations

Ethical approval for the study was obtained from Heriot-Watt University's School of Energy, Geosciences, Infrastructure and Society (EGIS). This section reflects on the key ethical considerations taken account in the study, before reflecting on the specific ethical challenges presented by the vulnerability of the population of interest.

4.5.1 Key ethical principles and protocols

One of the most integral aspects of ethical research when human subjects are involved is obtaining informed consent. Informed consent is a process that ensures that participants' autonomy, independence and respect of their rights for making informed choices are prioritised over obtaining data for the purposes of research (Wiles et al., 2007). In detail, the purpose of a consent form is to inform participants about their rights, the aims of the project, the benefits and potential stresses or discomforts that may emerge, as well as the exact procedure that it will be followed. Participants should be given opportunity to ask questions about the study, decide whether they would like to participate or not and be made aware about their rights, such as the right to 'opt out' at any time during the process. The British Sociological Association (BSA, 2017, p. 5) asserts that consent forms *"imply a responsibility to explain in appropriate detail, and in terms meaningful to participants,*

what the research is about, who is undertaking and financing it, why it is being undertaken, and how it is to be disseminated and used".

This being so, participants were asked to sign a consent form which was plainly written prior to any interviews and focus groups (see Appendix I). Literacy issues amongst interviewees were anticipated and consent forms were also verbally explained. This involved offering information about the project, participants' roles and responsibilities, extent of anonymity and confidentiality, as well as benefits and risks associated with participation. In addition, participants' ethical rights, purpose of the study, method and procedure were all made clear to all participants (see Appendices J & K). Particular attention was given to the voluntary nature of the study. Participants were informed that besides the fact that they could withdraw at any time and be free of any consequences, they could also choose not to answer particular question(s) that they may not feel comfortable with. It was also made clear that their decision about whether or not to be involved in the study would not have any impact on their eligibility for the service provided by the recruiting agencies or any other organisation. Adequate time was given for them to ask questions or clarify any aspects that they might have been unsure about. The researchers' and main supervisors' contact details were also provided for future reference.

In addition to the rights of research participants to information and free choice, confidentiality and anonymity given to research participants should be honoured at all times (BSA, 2017). The researcher ensured that no identifiable information about individuals collected during the process of research was disclosed without permission. Safeguarding the anonymity of participants was paramount. This was ensured by using codes as unique identifiers, while transcripts were accessible only to the investigator and supervisors. All audio recordings, transcripts and demographic data were encrypted and stored in password protected files. All files were kept on the university's secure server and will be destroyed upon expiration of the data retention period.

As mentioned above, participants were informed that there might be certain situations wherein breaching confidentiality would be necessary, that being in instances of disclosure that the safety of participant (or anyone else mentioned in the interview) was at risk of harm. Participants were alerted to this possibility during the consent process. Had the occasion arisen, the need to disclose any information would have been further discussed with participants prior to sharing any details to a third party. As it was, there was no need for breaking confidentiality during fieldwork as no such instances arose. In two cases where participants asked the researcher for assistance with accommodation issues, they

were directed back to the support workers on shift and both cases were followed through by the support staff.

4.5.2 Challenges associated with participant vulnerability

The significant vulnerability of research participants and the challenges that come with it represent additional ethical issues that required careful consideration. The ethical guidelines for conducting research with homeless populations assert that there are inherently ethical questions that need to be addressed due to fact that by definition this is a marginalised population that 'routinely experiences exploitation' (see Asfour, 2004; Runnels et al., 2009). Therefore, there is a compelling argument to balance autonomy and dignity with the need to 'protect' participants throughout the research process. McGovern et al (1998, p. 293) argues that when people are affected by mental health issues and/or addictions they *"require additional ethical guarantees that respect their sense of dignity"*. Furthermore, in MEH populations where people are vulnerable by virtue of factors such as homelessness and other forms of social exclusion (institutional care, involvement in street culture activities, etc.) there is an additional need for sensitivity.

Socially sensitive research entails the development of a protocol for addressing risks and safety implications presented by the research procedure. In the examination of the risks when researching vulnerable people, the moral challenge of obtaining informed consent was discussed throughout the design of the methodological stages of the research. It was further suggested that the abuse of illicit drugs, which is a common phenomenon amongst MEH populations, may pose additional methodological constraints on obtaining informed consent (see Runnels et al., 2009). In avoiding the aforementioned risks, staff members' judgement was consulted at all times and the agency's guidelines in working with homeless people were followed throughout. As previously noted, participants were sampled, in part, based on the personal judgement of the researcher and staff. Additionally, the researcher spent some time within each agency prior to commencing the interview process in order to familiarise herself with the service's procedures and meet staff members. This familiarization process also allowed potential participants to ask questions and discuss any potential worries. In this process, the particular circumstances of people that have experience MEH were also considered. For instance, homeless individuals may at times lack social stability and/or may be difficult to access and schedule appointments (Meade et al., 2002), thus a flexible attitude around those issues was ensured.

The above steps ensured that potential for harm was minimised, while every attempt was made to inform participants of the subjects of the discussion, the sensitive nature of

the study (i.e. personal questions), and the support available. A critical risk was that the length and type of the interview might leave some participants feeling unable to complete the interview and/or feel tired or experience distress. Furthermore, some ASI and other interview questions are by their very nature sensitive and considered as having difficult emotional content with potential to cause discomfort. In particular, recalling childhood memories and discussing relationships with important others has the potential to trigger distressing emotions. Bernard (2005, as cited in Liamputtong, 2006, p. 40) in her study on the impact of drugs on parents and siblings argues that *"interviews may prompt the participants to confront a part of their lives that they may have tried to conceal, hence, they may not like to be asked about it and may become upset"*. Similarly, people that have experience of MEH may disclose painful experiences that can cause emotional distress.

For addressing the above concerns, key-support workers who were familiar to participants and a clinical psychologist (who is also an external supervisor of this study) with a considerable experience in the homeless field were available to offer support to any participant who might exhibit signs of distress. Furthermore, the investigator of the study is a qualified person-centred counsellor, and soothing techniques for channelling thoughts and emotions upon the completion of the interviews were offered. This included checking in every so often with interviewees, wrapping up and reframing interviews and gently preparing for the end of the interview process. Participants were made aware that they could opt to stop the process at any time and in cases of signs of distress interviews would terminate. Contact numbers of available counselling services were also available to be given out to participants prior to commencing the interview process.

The psychological and social well-being of participants was considered paramount, thus the set out protocol was reviewed with the study's supervisors throughout the lifecycle of the study. Although a few participants became emotional while discussing emotive material, the interview process allowed enough time for them to relax and gradually move towards less personal questions. The interview plan was designed in such a way to allow participants to establish and maintain an appropriate degree of emotional distance from any experiences that were previously discussed (moving gradually from attachment experiences to participants' views of services). Having an empathic stance, actively listening, and providing enough time to participants to discuss their experiences seemed to be particularly effective. For instance, a number of participants discussed feeling at ease and experiencing some relief upon sharing personal experiences that they had never had a chance to discuss before. As the ESCR (2017) acknowledges, in some case participants

may benefit from discussing personal issues with a person they do not know in a setting that is bound by confidentiality.

4.6 Limitations

As with most qualitative studies which focus on studying a phenomenon or an event in a certain context, the generalizability of this study's findings is limited. The fact that the study focuses on the attachment experiences in the extreme manifestations of homelessness and related forms of social exclusion suggests that distinct analyses for other forms of homelessness may be necessary. Generalizability of casual explanations and interrelationships to similar settings may be only possible to a certain degree. The selection of four case study agencies in Scotland, and the limited number of service user and staff participants involved restricts the transferability of findings to other contexts. In all, embodying a critical realist perspective in most aspects of the philosophical and methodological design of this study implied that focus lay in studying participants' social reality rather than producing generalizations about it. That said, it is worth mentioning that previous studies on social attachment point to the universality of the phenomenon. In particular, cross-cultural attachment studies have led researchers to conclude that attachment experiences and styles are universal (Van Ijzendoorn et al., 2008). Nonetheless, consideration of both universal trends and contextual determinants is advised.

As previously discussed, the sensitive nature of the questions when combined with the duration of the interview could potentially cause discomfort for some participants in engaging in deeper self-reflection. For instance, remembering and reflecting on negative past experiences can increase the number of withdrawals during interviews. Furthermore, the higher prevalence of drug, alcohol and mental health problems could further compromise data collection. Previous research suggested that compromised populations such as those who are homeless may be more likely to answer questions that they think will 'please' or meet the expectations of the researcher (Liamputtong, 2006). Although allowances were made for breaks during interviews, the time consuming nature of the interview may have caused participants to feel tired or lose concentration. The fact though that interviews were primarily focused on participants' life experiences nevertheless assisted in keeping their interest and focus throughout the interview. Additionally, the fact that the researcher had extensive experience in conducting research with vulnerable and distressed individuals (within a mental health clinical setting), assisted in minimising any discrepancies and allowed for an open and warm environment to be developed.

Conclusion

This chapter provided a detailed account of the study's methodology for generating and analysing the collected data. It summarised the strengths and limitations of the adopted methods and described the ethical issues involved when conducting research with the particular population of interest. A primarily qualitative design was deemed most appropriate for addressing the research objectives and gaining a deeper understanding of the complexities of attachment experience. In addition, given the study's focus on the underlying psychological mechanisms that interplay when MEH populations engage with support, a critical realist perceptive was chosen for informing the analysis. Data on the attachment styles and related experiences of service users were collected via demographic and ACE questionnaires, a standardised interview (ASI) and a follow-on interview. For capturing the range of behaviours and emotional responses of staff members when working with challenging clients, focus groups were conducted. As to any research with vulnerable populations, great care was taken to minimise potential risks and build trust with participants. Emphasis was given in designing a research protocol that ensured the safety of both the interviewees and researcher. An in-depth analysis of findings and a synthesis of meaning is presented within the next four chapters.

CHAPTER 5: Attachment Styles and Other Descriptive Characteristics

Introduction

This chapter addresses the first research question, that being, what is the attachment style exhibited by individuals that have experiences of MEH? It does three things before focussing explicitly on this question. First, it provides an overview of the key socio-demographic characteristics and domains of MEH experienced by the 30 service user participants. This is followed by an account of the type and number of ACEs they reported. A review of the quality of their relationships, as assessed by the ASI, is then provided. The remainder of the chapter focusses on the prevalence and manifestation of participants' attachment styles. Quotations and descriptions of participants' narrative style, and dimensions of their relating behaviour (e.g. closeness or distance in relationships), are provided throughout the chapter.

5.1 Sociodemographic characteristics and experiences of MEH

All participants completed the demographic form responding to questions about age, gender, ethnicity, accommodation status and MEH related experiences. Table 5.1 provides a general overview of the various characteristics of the sample from these data. The ages of the 30 service user participants ranged between 19 and 52 years. In line with existing literature, participants were predominantly male (n=20) and were mostly within middle age ranges (36-49 years old) (Bramley & Fitzpatrick, 2018). Nonetheless, female participation was considered to be disproportionally higher in this study when compared with similar studies. This may be attributed to the fact that one of the main recruiting services was running small courses for women to allow participation and increase service accessibility of this often invisible and potentially more vulnerable subgroup.

In relation to the accommodation status, when the interview took place the majority of participants were either staying in hostels and B&Bs (n=15) or sleeping rough (n=8). Shelters were providing accommodation for three participants, while only a small number (n=3) were in temporary accommodation at the time. Out of those three participants, one was a female. It is notable that most women were avoiding staying at the shelters or rough sleeping. In particular, only one woman was using the shelter at the time along with her partner, six women were staying in a B&B or a hostel, and two were sleeping rough.

In regards to the age of first instance of homelessness, the findings were somewhat mixed for participants. Half of the sample first experienced homelessness after the age of

26 (n=16), while one third of participants experienced homelessness early in their lives (usually before the age of 16 years old). No gender differences were noted when age of first homeless episode was examined. Similar conclusions were made in regards to the length of the most recent episode of homelessness. Almost two thirds of the sample had been homeless for more than a year (n=17), while the remainder had been homeless for less than a year (see Table 5.1).

The demographic questionnaire was also designed to capture three further domains of multiple exclusion in participants' lives, those being experiences of substance misuse, institutional care and involvement in street culture activities at any point in adulthood. It is noteworthy that the overall prevalence of MEH-relevant experiences was overwhelmingly high. In particular, all but one participant reported having experienced substance misuse problems, while the vast majority of participants had been involved in street culture activities and had at least one institutional care-related experience. The most common form of substance misuse was the use of hard drugs (n=22), while experience of alcohol problems were also common (n=18). The sample also reflected a high number of experiences of institutional care. Prison was the most commonly reported form of institutional care (n=17). As Table 5.1 illustrates, a smaller number of participants also reported admission to a mental health hospital (n=8) and/or having lived in local authority care in earlier life stages (n=7). Finally, over half of participants had been involved in street culture activities. Begging (n=20) and survival shoplifting (n=21) were reported most commonly, while street drinking was also reported by almost half of the sample (n=13).

Overall, this was a group that combined experiences of homelessness with one or more indicators of deep social exclusion. For the majority, homelessness was a particularly prevalent form of exclusion which defined and shape their identity. In all, participants differed in length of time being homeless, the number of homeless episodes they have experienced and their accommodation status. Some minor gender differences were also identified. Despite variations in participants' experiences, the complexity of needs and the high levels of social exclusion were common themes. In accordance with previous findings (Fitzpatrick et al., 2012) more than half of the sample had experienced all four domains of social exclusion identified. The high degree of overlap between specific MEH-related experiences depicted the multiple layers of exclusion and complexity of the group. To add to this, troubled childhoods further deepened problems and brought people at the sharpest end of society. These are discussed in the next section.

AGE	N	GENDER	N
Under 26 yrs.	2	**Female**	10
26-35	7	**Male**	20
36-49	16		
50+	5		
Total			30
ETHNICITY		**Age of first episode of homelessness**	
White Scottish	21	**>18**	12
White English	6	**18-25**	3
Other European	3	**26-35**	8
		36-49	7
Current Accommodation status		**Number of episodes of homelessness**	
Staying at a night shelter/hostel/B&B	18	**One**	2
Sofa-surfing	1	**2-5**	19
Sleeping rough	8	**6-10**	6
In accommodation	3	**11-29**	3
Length of Current episode of homelessness		**Substance misuse**	
1-6 months	8	**Ever had a period of <6 alcoholic drinks on a daily basis**	18
7-12 months	5	**Ever injected drugs**	22
1-2 years	11	**Ever abused solvents, gas or glue**	7
2-5 years	4		
5+ years	2		
Institutional Care		**Street Culture activities**	
Ever went to prison	17	**Ever involved in street drinking**	13
Ever admitted to hospital because of mental health issue	8	**Ever shoplifted**	20
Ever left local authority care	7	**Ever begged**	21

Table 5.1. Demographic characteristics of final sample of service 30 users (N=30)

5.2 Adverse Childhood Experiences

Experience of childhood adversity was found to be substantially overrepresented in the sample population (see Table 5.2). This finding was not surprising as previous literature indicates a strong association between homelessness and childhood adversity (see chapter

3). However, what was of particular interest was the accumulation of multiple adversities. Examples of ACEs included physical, emotional and sexual abuse, emotional and physical neglect, household mental illness, parental separation and household substance abuse. A total of two thirds of participants experienced four or more ACEs, and almost one third scored extremely high (8, 9 or 10 ACE). Previous research suggests that the accumulation of ACEs, rather than any one particular ACE, is the strongest predictor of negative outcomes. This finding is particularly alarming considering how four or more ACEs are a criterion for elevated risk of chronic mental health problems (Wade et al., 2017 as cited in White et al., 2019).

Overall, only one participant did not report any ACE and only four participants reported less than three exposures to adversity. The most commonly experienced adversities were physical and psychological abuse, emotional neglect, substance abuse in the household, and parents being separated or divorced. The least prevalent adversity categories included being physically neglected as a child and being exposed to criminal behaviour in the household. In detail, responses related to direct harm were as follows: 21 participants reported physical abuse, 21 reported psychological abuse, 13 reported sexual abuse, 19 reported emotional neglect, and 10 said that they were physically neglected as a child. Severe stressor exposure is not solely related to direct forms of harm, but also via witnessing acts of violence and suffering neglect when significant adults are unavailable to provide care. In relation to the stressful experiences that affected the environment in which participants grew up, the rates were again significantly increased. In particular, 22 participants indicated that their parents were separated, and/or were abusing drugs or alcohol (n=19), and/or were suffering of serious mental health issues (n= 14) during their childhood. One third of participants also reported that a close family member was in prison while they were growing up, and half of the sample (n=15) reported that their mother was treated violently within the household (see Table 5.2).

The probability that individuals who were exposed to any single category were also exposed to another category was high. Previous research suggests that ACEs come in groups and exposure to one category increase the probability of exposure to another by 80% (Felitti et al., 2002). Within the sample, all participants who were exposed to physical abuse responded also positively on psychological abuse and emotional neglect. Similarly, when participants reported sexual abuse, psychological abuse and emotional neglect also tended to have been experienced. In addition, for the majority, emotional neglect appeared to be correlated with physical neglect. In relation to indirect harm, ACEs also appeared to

be strongly interrelated. Participants that reported that their parents were separated also tended to report exposure to domestic violence.

Similarly, living with a parent that abused drugs or alcohol interlinked with parental mental health problems and exposure to domestic violence. In relation to gender specific differences, females scored particularly high. Female participants responded positively to most categories (six, seven or eight adversities categories out of 10). Physical abuse and psychological abuse were most commonly experienced by women, while experience of growing up with a single parent was also common. There were no notable gender differences in the prevalence of experience of emotional neglect or growing up with a problem drinker or a family member who used drugs.

Number of ACEs	***female***	***male***	***total***
Zero	-	1	1
One	-	3	3
Two	1	-	1
Three	1	2	3
Four to seven	4	9	13
Eight to ten	4	5	9

Type of ACEs	***female***	***male***	***total***
Physically neglected as a child	4	6	10
Emotionally neglected as a child	6	13	19
Psychologically abused as a child	7	14	21
Physically abused as a child	7	14	21
Sexually abused as a child	5	8	13
Grew up with a mentally ill, depressed person or someone who attempted suicide	6	8	14
Grew up with a problem drinker or a family member who used drugs	6	13	19
Parents separated or divorced	8	14	22
Incarceration of a household member	6	4	10
Mother treated violently	6	9	15
	Base n=30		

Table 5.2. Number and Type of ACEs amongst sample (N=30).

Overall, this was a sample with disproportionate experience of multiple trauma. As somewhat expected the prevalence of ACEs were much higher within this deprived population when compared with less deprived ones. In the original US-ACE study (Felitti et al., 1998), out of the 17,000 participants, two-thirds had experience at least one ACE and one in five individuals had experience of three or more early life traumas. It is notable that in that study participants were mostly of middle and upper middle class. Other studies that looked at the general population, found similar results with half of their samples

experiencing at least one ACE and the minority (usually 1/10) reporting exposure to three or more (Bellis et al., 2014; Ashton et al., 2016). Although pervasiveness of ACEs in the general population is considered to be high, the contrast when compared with deprived samples, such as this study's sample population, is intensified.

As discussed in chapter 3, ACEs should be primarily considered at an individual level. Grouping ACEs together in a cumulative score and making inferences just based on this score, may often lead to false assumptions, such as that trauma consequences are the same for each individual. On the contrary, stressful life experiences are likely to have different and heterogeneous consequences for each participant, based on duration, timing and severity. In this vein, ACEs have been recently criticised as being a 'chaotic concept' (White et al., 2019) which emphasizes risks and obscures the contextual factors in participant's life. The rating scales usually do not take into account who the participant is, nor can they provide an indication of how best to intervene. For tracing valid casual inputs and effects of ACEs, those conditions should be thoroughly considered. In any case, whilst a helpful tool, ACEs scores should be viewed with caution, especially when are seen as the main risk factors for a variety of symptoms.

In relation to social environment, within this sample, indirect factors such as family stability and security, as well as other contextual factors such as socio-economic deprivation and poverty clearly played a role in trauma presentations. Research evidence suggests that deprivation can increase the likelihood for more ACEs and impacts on the severity and nature of trauma (see Chapter 3). Poverty for instance may not cause neglect in a direct fashion, but inadequate housing and not having enough to eat can have a powerful impact on growth and development. Although those factors were not researched in any systematic way, domestic disadvantages were common experiences amongst the sample; with one third of participants having experienced physical neglect as a child and growing up with a parent that was involved in the criminal justice system.

The subject of the duration and type of impact of ACEs on the individual has received a lot of attention within literature (see chapter 3). ACEs are a major source of psychological distress which can lead to increased risk for chronic conditions over time. The immune system is weakened and coping capacity is altered and undermined (Bellis et al., 2014; Bellis et al., 2015). In this vein, participants commented on the role of early stress in their lives (e.g. its role on using substances and on their mental health) and amongst others discussed having an increased sensitivity to stressful events. ACEs have been linked to a heightened possibility for additional physical and emotional trauma in later life stages. At times, participants were able to make meaningful connections between early adversity

and current status. Tracing their homeless situation back to early trauma was reflected in their narratives (see chapter 6 & 7 for a full discussion). For instance, Gary, a male participant who ticked eight types of adversities on the ACE questionnaire, discussed:

> "My dad didn't do nothing. He was a drinker and I started drinking from a very young age too. I was getting ignored, not fed and properly taken care of. My mum chucked me out when I was 16 and she left me to be on the streets and she didn't bother about it. I was totally unprepared. […] I do wish I grew up differently or the same as other folks, I wouldn't be here today, I wouldn't be homeless".

Nonetheless, physical, social and psychological factors can also temper the effects of adversity. For instance, for a few participants the role of an extended family member was crucial for alleviating their distress and adversity experienced in the close family environment. In the following example, a female participant explained how her relationship with her aunt enhanced her ability to cope with adversity. Suzanne was staying with a parent who was using drugs and she was often exposed to domestic violence. Her mother had mental health problems and she was often treated violently by her father. Eventually her parents were separated.

> "My mum is in a mental health hospital, she is bipolar. I couldn't stay with her I was often staying with my aunt. She is the mum I never had. She has always been there, when I left home and when I needed food. My aunt stuck out when I needed her, unlike my mum. I had someone to talk to and go to, she wasn't there to judge me or shout at me".

Overall, the high levels of life trauma and early adversity not only interplayed in triggering MEH and posing barriers for recovery but further increased vulnerability of a population at the sharpest end of problems. MEH populations routinely report disproportionately high levels of abuse, neglect and other forms of severe adversity. The socio-economic deprivation and disadvantage that often underpin their backgrounds played a dynamic role and one might argue that it should 'count' as an additional ACE. Pervasive and severe early trauma in most cases was accompanied by a lack of stability, security and protection over extended periods of time while growing up. As a result, individual's social, emotional, personal, cognitive and behavioural functioning can be undermined, often leading to the development of chronic physical and psychological symptoms. Those experiences interfered with the formation of secure attachments and impacted on the quality of participants' relationships, as discussed in the next section.

5.3 Quality of relationships

According to the construct of attachment and the ASI, participants' degree of insecurity may be rated as *marked, moderate* or *mild*. As the interview assesses the characteristics of participants in terms of their quality of close relationships and the amount of social support that the individual has access to regularly, the degree of security gradually emerges. In detail, levels of security may be derived by assessing the quality of the relationship of three important support figures in participants' lives, referred to as Very Close Others (VCOs). The VCOs were selected by participants at the start of the interview and each relationship was further explored to find out about the quality of support they provided. Very good support or good-average support was determined when high levels of confiding or sharing of personal information on important issues was identified. Confiding primarily encompassed personal feelings and worries. When emotional and practical support was reciprocated the relationships were rated as supportive enough. In contrast, when scores were low on those scales, relationships were rated as providing insufficient, inadequate or no support. Relationships were also rated as discordant or not discordant based on the levels of negative interactions between individuals. The assessments for each participant are summarised in Tables 5.3.

The great majority of participants were able to identify at least one person that they considered as their close other (n=25). Only a few participants were not able to identify any close relationships (n=5). Most participants identified their partner as their VCO, and occasionally a friend or a relative. Nonetheless, when the supportiveness of the relationship was assessed it appeared that their overall quality was particularly low for the vast majority of participants. These relationships were often lacking warmth, affection and positive interaction. The levels of actual confiding were very low or non-existent and the negative interactions significantly outweighed any positive ones.

In detail, out of the 25 participants who were able to identify a close other, only 6 participants had one relationship that was rated as good on quality. Those 6 were rated as *moderately* insecure due to their capacity to build and maintain at least one supportive relationship. The remaining relationships were assessed as being insufficient and inadequate on quality and support. According to the ASI scoring, the remaining 25 participants were rated as *markedly* insecure. In a sense, their ability to make and maintain close bonds appeared to be compromised as their formed relationships were lacking warmth, closeness and support. In most cases those relationships were characterised as co-dependent (usually drug-related) and/or abusive. In particular, the assessment of those relationships revealed high negative interaction (violence, intense and frequent rows and

arguments, tense atmosphere), low levels of confiding, and low or no effective support was offered. Low levels of confiding also applied in cases where the interviewee did not actively confide much even if the support was offered and/or when low supportive characteristics were attributed to VCOs (e.g. when VCOs appeared to be disinterested in listening or exhibited high criticism and disapproval).

Quality of the relationship	Participant	Age	VCO's
A. *Good average support (Discordant or not discordant**)***	Ellen	29	Partner (Discordant)
B. *Insufficient support (Discordant or not discordant)*	Michael	46	Friend (Not Discordant)
	Peter	45	Partner (Not Discordant)
	Jenny	36	Partner (Not Discordant)
	Phillip	50	Sister (Not Discordant)
C. *Inadequate support (Discordant or not discordant)*	John	43	Brother (Discordant)
	Christy	39	Partner (Discordant)
	Harry	56	Partner (Not Discordant)
	Alan	34	Mother (Not discordant)
	Emma	40	Partner (Not discordant)
	William	49	Partner (Discordant)
	Carole	44	Mother (Discordant)
	Mark	35	Sister (Not Discordant)
	Daniel	36	Partner (Discordant)
	Patrick	52	Ex-Partner (Not Discordant)

	Donald	50	Friend 1 (**A.** Not Discordant)	Friend 2 (**A.** Not Discordant)

Participants who could identify more than one VCO ***A. Good Average support*** ***B. Insufficient Support*** ***C. Inadequate Support***	Sarah	35	Partner (**B**. Discordant)	Friend (**A**. Not Discordant)
	George	39	Partner (**B**. Not Discordant)	Daughter (**B**. Discordant)
	Suzanne	29	Partner (**B**. Discordant)	Aunt (**B**. Not Discordant)
	Wendy	37	Partner (**B**. Discordant)	Sister (**B**. Not Discordant)
	Laura	19	Friend **(A.** Not Discordant)	Stepmom (**B**. Not Discordant)
	Paul	21	Friend **(A.** Not Discordant)	Father (**B**. Not Discordant)
	Thomas	38	Partner (**B**. Discordant)	Mother (***C.*** Discordant)
	Maggie	27	Partner **(A.** Discordant)	Aunt (**B**. Not Discordant)
	Nick	36	Friend (***C.*** Discordant)	Grandma (***C.*** Not Discordant)
Participants who could not identify any close others	Robert, 29; Andrew, 52; Gary, 44; David, 36; Ian, 36			

Tables 5.3. Close others and quality of the relationship

5.4 Participants' attachment styles

As noted in Chapter 4, the ASI identifies five main attachment styles. One is clearly secure. The other four types are insecure and include: enmeshed, fearful, angry-dismissive, and withdrawn. The ASI classification refers to the current attachment style of participants as opposed to a historical one. In this vein, the collected evidence and examples delineated participants' attachment experiences over the past 1-2 years, unless it was deemed important to explore beyond this time-frame. Two of the aforementioned styles are located in the anxiety dimension (enmeshed and fearful), and the other two (withdrawn and angry dismissive) are characterised by avoidance. At times, it was necessary to rate more than one insecure style when two distinct attachment style profiles emerged. In those instances, participants were rated as having a dual/disorganised insecure attachment style (see Figure 5.1). The more pervasive and dominant attachment style, across a range of relationships,

was prioritised in analysis, albeit both styles were determining the overall attachment style (this being dual).

As previously discussed, upon the exploration of close relationships, the interview was focused on participants' general style of relating to others. This was assessed in terms of levels of mistrust, constraints on closeness (e.g. feeling comfortable to ask for help), fear of rejection and separation, self-reliance, desire for company, and anger/hostility levels. According to the ASI guidelines, the scales reflected anxiety and/or ambivalence when participants scored high on the desire for company and low on self-reliance and when exhibited high intolerance of separation and a high fear of rejection. At times, attachment anxiety involved high anger; typically, when dependency needs were not met.

The scales reflected avoidance and/or anger when participants scored low on the desire for company, but high on self-reliance, anger and constraints on closeness. An individual's location in the two-dimensional scale not only indicated their specific attachment style but also provided information on the strategies that they may use when coping with stress and loss. In particular, as discussed in chapter 3, insecure individuals suffer from high insecurity and low self-worth and employ *secondary strategies* to cope with their distress. Those refer to the *hyperactivation* and *deactivation* of the attachment system. Individuals high on attachment anxiety rely on *hyperactivating* strategies and those scoring high on avoidance rely on *deactivating* strategies for coping and seeking help (see also chapter 7). With these ideas in mind, an analysis of attachment styles of the sample will follow.

Overall, results indicated that the global scores of insecure attachment were high. Within the sample no secure attachment profiles were identified. All 30 participants (and the three pilot interviews that were not included in the final sample) displayed an insecure attachment style. The sample comprised 20 participants displaying an anxious attachment style and 10 displaying an avoidant attachment style (Figure 5.1). Of those who fall into the anxious category, 10 participants were rated as having a fearful style of relating and the other 10 were rated as having a primarily enmeshed style of relating. Out of those who fall into the avoidant classification, six were rated as having a withdrawn style and four as having a primarily angry-dismissive style. The above attachment styles are participants' primary attachment pattern (see Figure 5.1).

More than half of the sample displayed a more complex attachment style that involved more than one attachment profile (see Table 5.4 for a summary). Dual attachment styles were particularly high within the sample (n=22). This style is usually characterised by a high risk in psychopathology and relational stability. In detail, the classifications of

14 participants were rated as 'contradictory' as a pull in both anxious and avoidance directions was present. For instance, a participant may be rated as having a dual Fearful/angry-dismissive style. However, for eight participants, both fear of separation and fear of rejection attitudes were rated as non-standard and could be attributed both an enmeshed and a fearful style. In other words, participants scored particularly very high on attachment anxiety and very low on avoidance. In those cases, participants were also rated as having a dual style; a Fearful/enmeshed or vice versa.

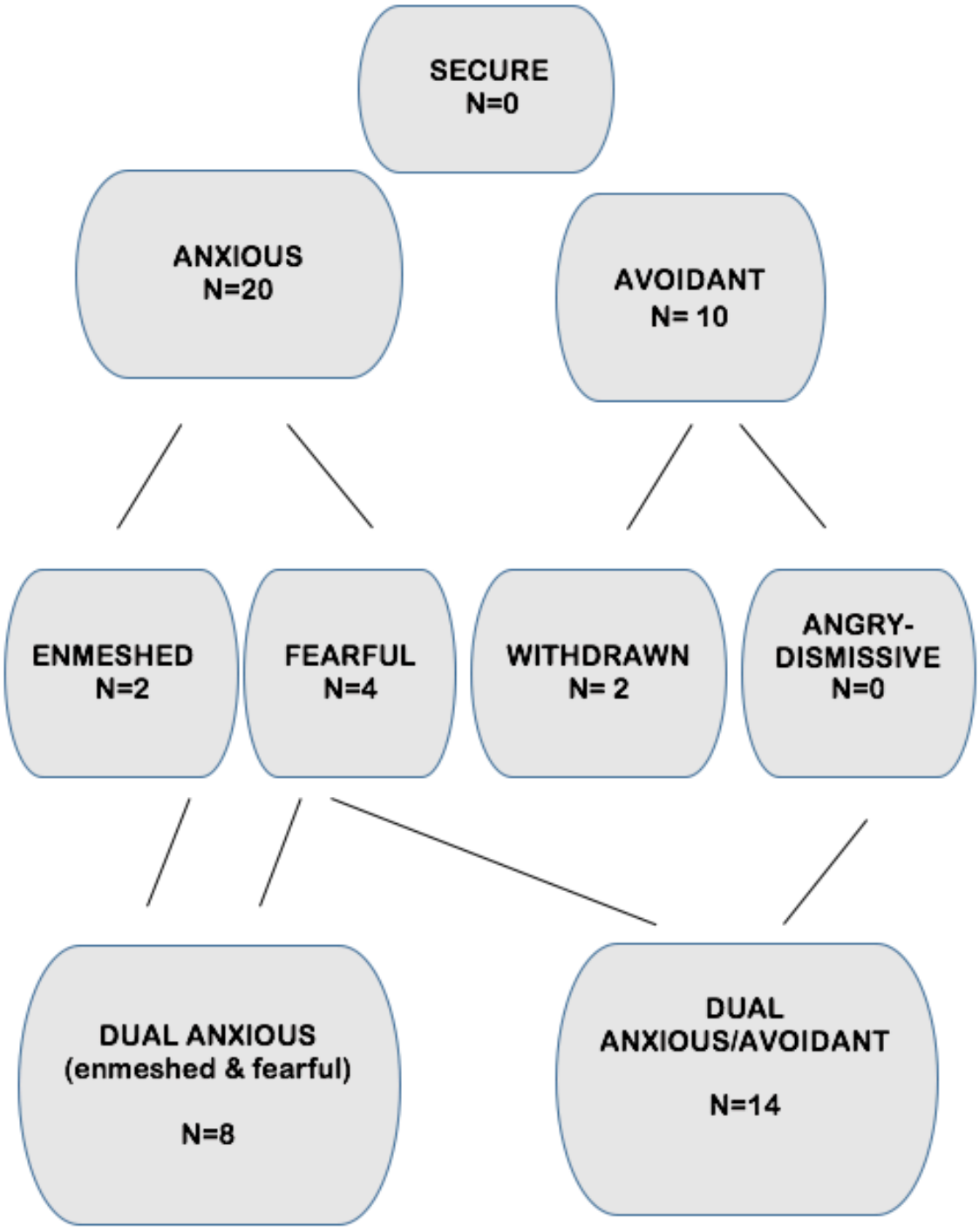

Figure 5.1. Classification of attachment styles within sample (N=30)

	Participant	Age	Level of Insecurity	Attachment Style
1	Donald	50	Moderate	Withdrawn
2	Sarah	35	Moderate	Fearful / Angry-Dismissive
3	John	43	Marked	Withdrawn/Enmeshed
4	Robert	29	Marked	Fearful
5	Michael	46	Marked	Enmeshed/Withdrawn
6	Peter	45	Marked	Withdrawn
7	Jenny	36	Marked	Withdrawn/ Enmeshed
8	George	39	Marked	Fearful/Angry –Dismissive
9	Christy	39	Marked	Enmeshed/Fearful
10	Andrew	52	Marked	Angry-Dismissive/Enmeshed
11	Suzanne	29	Marked	Fearful
12	Phillip	50	Marked	Fearful/ Angry-Dismissive
13	Gary	44	Marked	Fearful
14	Wendy	37	Marked	Enmeshed/ Fearful
15	Harry	56	Marked	Enmeshed/ Withdrawn
16	Laura	19	Moderate	Enmeshed
17	William	49	Marked	Angry-Dismissive/Enmeshed
18	Paul	21	Moderate	Enmeshed
19	Carole	44	Marked	Enmeshed/Fearful
20	David	36	Marked	Angry-Dismissive/Fearful
21	Allan	34	Marked	Fearful/ Enmeshed

22	Emma	40	Marked	Withdrawn/Enmeshed
23	Ellen	29	Moderate	Fearful
24	Mark	35	Marked	Withdrawn/Enmeshed
25	Thomas	38	Marked	Enmeshed/ Angry-dismissive
26	Daniel	36	Marked	Enmeshed/ Fearful
27	Maggie	27	Moderate	Enmeshed/ Fearful
28	Ian	36	Marked	Fearful/ Enmeshed
29	Patrick	52	Marked	Angry-Dismissive/Fearful
30	Nick	36	Marked	Fearful/ Enmeshed

Table 5.4. Attachment styles & Level of insecurity

5.4.1 Anxious attachment styles

Enmeshed

Individuals with an enmeshed attachment style tend to manifest high dependency needs in their close relationships. They may exhibit a high need for contact with others (high desire for company) and their style of coping usually entails persistent seeking of advice and help from others (low self-reliance). Enmeshed individuals tend to have a low tolerance of separation from their close others even for shorter periods, and they occasionally exhibit high distress when not in contact (high fear of separation) (Bifulco et al., 2014).

Their reporting style is usually full and emotional. At times it may involve high anger, typically when attachment needs are not met. As expected, avoidance characteristics are low. On the contrary, they have a tendency to trust others (low distrust) and do not have many constraints on confiding and being open (low attitudinal constraints on closeness) (Bifulco et al., 2014). At times they may be overly expressive and have a difficulty in setting their personal boundaries.

When marked or moderate insecure levels are displayed, their need for contact is usually heightened. In those cases, they may appear to have a high number of contacts but those relationships tend to be fairly superficial. Closeness, support and confiding in times of crisis may not be achieved in most of those relationships. At the extreme, enmeshment is associated with incoherence and contradictory reporting (Bifulco et al., 2014). This may be due to their proneness to have an idealised view of others even when an actual situation does not match their expectations.

The following extracts are from a participant who was assessed as being *markedly* enmeshed/fearful. Daniel (44 years old) reporting often seemed to contain contradictions, while his high desire for closeness and intimacy was often mentioned throughout the interview. Daniel also discussed how his homeless status affected his ability to create relationships. This participant did not report any close relationship but mentioned a number of acquaintances that he has contact with.

> "Yes, it is important to have someone close to me. I think it is just that I didn't have anybody that close to me for ages. Like I wasn't that close to my dad or mum either, probably I have never been that close to anybody. […] I don't think that out of fear of rejection, I might not get close to others. It is just that it makes me feel

uncomfortable, it can be scary because I haven't been there, if that makes sense. […] I do want to be close to someone".

In terms of self-reliance and making decisions the participant's responses were somewhat contradictory. Although Daniel disclosed high levels of trust and valued closeness, he expressed difficulty in engaging with support when in crisis and exhibited elements of over-dependency on others.

> "I think I trust more than I should, I would say that the problem is more with over trusting people. […] I don't cope well alone, probably I would cope better with somebody else's help, I don't know. I do need to go and get advice here or there. Sometimes, I don't know how and others I just don't go. […] I do ask for others' opinions. I would probably ask lots of folks. I might get six different answers and then decide which one to take".

In a similar vein, Wendy, a 37 years-old female who was assessed as having a *markedly* dual style (as scored non-standard on the fear of rejection and fear of separation scales thus assessed as enmeshed/fearful style), reflected on her high dependency on others and her fear of separation and rejection. Overall, her reporting style was full and emotional and she often diverged onto other topics.

> "Yes, I feel very anxious when he [partner] goes away. When he is going to his mother, I think he is meeting ex-girlfriends. If he is late, I will go mental. I go nuts and start screaming. […] Being alone does bother me, I used to be really bad at that. It may sound stupid but one time not long ago, me and my partner fell out. We were fighting a lot, physically too, really bad and I was at home alone and I called 999 because I was feeling suicidal and it was more of a cry for help. […] I am very dependent when it comes to making up my own mind. I ask people. There are a lot of things I wouldn't do, unless my partner tells me to do. This is who I am".

Fearful

The defining feature of fearful individuals is that they avoid close relationships out of fear of been rejected or let down (high fear of rejection). This high fear of rejection is a unique feature of this style and often entails high mistrust due to such fear. This anxiety is often related to actual experiences of being hurt or rejected and consequently feeling

regretful for being open and allowing intimacy. Their mistrust levels and attitudinal constraints on closeness are high (Bifulco et al., 2014). Fearful individuals usually have a desire for closeness but together with a fear of being hurt, they tend to experience high levels of loneliness. Bifulco et al. (2014) noted that an underlying anxiety is more often present when discussing emotive material. When marked or insecure levels are present, individuals may attribute relationship failures to themselves (high self-blame). This internalisation of relationship failures often links with low levels of anger. On the whole, their reporting style is usually full and expressive.

The following quotations are from a 29-year-old, female participant (Ellen) who was assessed as having a *moderate* fearful style of relating. She explained: *"Yes, I have been rejected and hurt and it can do, stop me from getting close to others. Definitely can, but it is hard to speak about it actually"* (she was emotional at this point). Ellen had a one-year long relationship and at the time of the interview she found herself homeless again as the relationship had broken down. *"I just need my close people around me, I don't like being alone".* In terms of self-reliance, Ellen noted: *"I will try and think it through if things I can't cope with. It is hard to see my life without him, and it is hard to see where I will be at, it is hard to see ahead".*

Another female participant (Sarah) with a fearful style of relating as her primary style discussed: *"I like being close to people but it is scary, because you get close to people and then they go away, or you are losing them again and you are ending up on your own".* In terms of her levels of trust, Sarah exhibited high levels of distrust; *"Yes, I am social but I very dubious about new people. I didn't let anybody to get to know me for long time".* She displayed a moderate desire for engagement and high attitudinal constraints on closeness. In particular, Sarah reflected on her difficulty to trust and confide to others, and her tendency to create distance rather than achieve closeness and intimacy. Her low and negative expectations about relationships and her pronounced feelings of rejection and hurt led to pushing people away. Those reactions were often incongruent with her need to secure intimacy and sustain closeness to others.

> "It was important (being close), but I just close all my emotions now. Because I have been out too many times, I have been used too many times. […] I don't confide to anybody, anything. I keep myself to myself. They can confide in me, this is not an issue, it's more of me doing it. […] Yes, sometimes, it is nice being

alone. Other it makes me feel lower, just sitting sad on your own. Sometimes it is not nice, I am not much of a loner. I do like to be around others more".

5.4.2 Avoidant attachment styles

Withdrawn

The defining characteristic of withdrawn individuals is that they tend to distance themselves from others. They defensively avoid dependence and have a strong desire for privacy. Withdrawn individuals tend to score high on the self-reliance scale and low on the desire for company scale (Bifulco et al., 2014). Their tendency to suppress their attachment needs and set clear boundaries with regard to others, can often lead to being socially isolated. They are prone to reject offers of support and often appear very practical and 'invulnerable'. In this vein, this may cause others to offer little assistance. Overall, their reporting style is often brief, factual and non-emotional (Bifulco et al., 2014). Withdrawn individuals have a deep-seated distrust of others and entrenched beliefs that one cannot rely on others to have their needs met. Unlike fearful individuals, they report little or no fear of intimacy while exhibiting low levels of anger. They tolerate separation and can 'easily' disengage from others, often by suppressing their feelings.

When marked or moderate levels are displayed, the deactivating strategies that these individuals employ are likely to hinder their ability to develop a heathy dependency to others. As a result, withdrawn individuals do not feel satisfied with their relationships, which are often characterised by decreased levels of intimacy and trust (Bifulco et al., 2014). Withdrawn individuals show an avoidant style of coping and often perceive that they are on their own and must deal with life stressors solely by themselves. Indeed, they find seeking and asking for help particularly uncomfortable.

A 45 years-old male participant (Peter) discussed his lack of interest in close relationships and his high need to feel in control and self-reliant. The participant was able to identify his partner as a close other. However, this was a long distance relationship and he was only meeting his partner once per year for a few days. Peter discussed that he feels content and satisfied in his long distance relationship, as getting too close does not 'work' for him. This participant was brief and factual in his narrative. He displayed low levels of anger and high mistrust towards others. In particular he stated:

"We never argue. We spent some days per year together and it is very nice. When we were together in the same place, it was a very complicated thing. It didn't work.

> […] No, I haven't been hurt in the past. I didn't give them the chance so that is why I keep a lot of things just for myself. I don't share because I don't want to get hurt, so to protect myself. I feel safer when people know less about me. […] I learnt to live alone. I really enjoy being alone. I do like people too but as I said I don't share everything. I do like to have company, talking and laughing but I like it more when it is quiet. I don't like violence or high volume and arguments. […] I feel independent, nobody can keep me in this place, every day, every time I can just pack my things and I am free. I can do anything I want to. I think that you should always decide on your own".

Similarly, a female participant (Emma) reflected on her difficulty to trust others and her inability to depend on others in times of need. Literature suggests that withdrawn individuals defensively strive to maintain behavioural and emotional independence and distance (Simpson & Rhodes, 2015). This participant viewed herself as being invulnerable to feelings associated with being closely attached to others. She identified her partner as her close other, however, levels of intimacy and closeness were particularly low. The relationship was formed on the basis of co-dependency and substance misuse, and emphasis was placed on meeting instrumental needs. Emma describe her relationship with her close other in the following way:

> "Some things are personal, it is hard for me to share. I won't go into much detail with him, I have always been like that, being closed to myself. I don't rely on him. I make my own money. If I need anything I will go out and do it myself. I only rely on myself. Me, myself and I. […] Yes I can manage without him, I have been there and I have done it and it will be ok. […] We are getting close but not as close as anything else. We are getting on aright but nothing closer than that. There is not much emotional involvement, I am not opening up to him. Everybody that I had close to me has died or goes away. So I don't want anyone close to me. I feel happy like that I don't know why I am like that".

Angry-dismissive

This style results from the subdivision of avoidance category into withdrawn-avoidant and angry-dismissive. This is a distinction only made in the ASI, and reflects the significance and impact of the anger component with regards to others. To be classified with this style, the anger rating has to be either marked or moderate. Key characteristics of the angry-dismissive attachment style are avoidance of others, together with high levels

of mistrust and anger towards self and others (Bifulco et al., 2014). Similar to withdrawn individuals, those with an angry-dismissive style exhibit low desire for company and score high on the self-reliance scale. They tend to be mistrustful and suspicious of others' motives and display conflict and anger in close relationships. Consequently, their dismissive stance towards others lead to them establishing barriers within relationships and often choosing to be on their own. On the other hand, although they appear to have few contacts they are rarely isolated (Bifulco et al., 2014). Nonetheless their relationships are unsupportive and most of the times are characterised by high discordance.

Overall, their reporting style can be tense and they can show irritability throughout the interview process. It is noteworthy that although anger and conflict characterise this style, this may be resulting from frustrated attachment needs. Bowlby saw anger as a form of protest to gain contact with the attachment figure. However, these powerful anger-related responses can be particularly dysfunctional and may continue in adulthood. In particular, individuals that were rated as *marked* exhibited dysfunctional anger and rejecting and hostile qualities. For the few participants with this style, violence was prominent in their lives and they were often convicted for violence-related crimes. Responses such as "*I am angry, I can be very angry and a nasty person, trust me"* (David) and *"I may punch you in the mouth and steal your wallet but I couldn't beg. I would rather go to prison than beg someone"* (Patrick) reflect the sentiments expressed by angry-dismissive individuals.

The following extracts are from two male participants that were assessed as being *markedly* angry-dismissive. The assessment was based on their answers when asked about relationships and intimacy, fears around separation and rejection, levels of anger, and mistrust towards others. Due to the pervasiveness of their anger, their high self-reliance and low desire for company, their relationships appeared to offer insufficient emotional support. In the first example, a 52 years-old male participant discussed the importance of relationships in his life. Patrick identified his ex-partner as his close other. His relationship was rated as been poor in regards to offering support, mainly because he was not disclosing any of his difficulties. Patrick was mistrustful of others and often exhibited anger and conflict within his relationships. In this vein, violence was a prevalent feature of his life and he was often in and out of prison as a result.

> "You can't trust anyone, because they are always up to wrong you one way or another […] I look after myself and I can't look after anybody else. I couldn't care less for anybody else, I am too old for that rubbish (relationships), I have been there, case is rested. It is not important for me to have someone close to me. I am just

> happy and content in myself. […] Why I don't get that close to people because I was probably let down a lot when I was younger. Probably you did me a favour there (participant realised his reasons for keeping his distances, while discussing it in the interview) but I will forget it when I walk out. […] I don't ask anybody, I do what I want to do and that's it. […] It was always the violence with me, and I have done the wrong decisions. I just can't control myself, I give people chances and I try to walk away now and I try to walk away until...I explode".

Similar to the above example, another participant, Andrew, discussed how difficult it was for him to make relationships and avoid interacting with others through his anger. This participant was of similar age (53 years-old) and again rated very high on anger and self-reliance and low on the desire for closeness. His reporting style was factual and non-emotional. He had a few volatile relationships but over the past few years he has been single. He was not able to identify any close others at the time of the interview. When asked about his ways of coping, he stated:

> "I used to deal with grief in one way, and that is attack and head on. Now there are two ways to deal with situations, you attack and head on or you walk away, so I prefer to walk away, and let it sort itself out".

When further questioned about his anger Andrew explained;

> "I get into very, very heated arguments. Having fights and that as well, yeah. I don't know why, I don't know. Maybe I wouldn't put it down to anything having to do with being homeless, maybe just myself. At one point I had a lot of anger issues, a lot, it was always a part of my life. I am now containing the beast in me, I don't want to hurt anybody but I do have radical views on things as well. I don't get into fights anymore, or I am trying to keep myself to myself, but I get angry not for myself because I believe I can look after myself to a degree but I get angry when I see other people very very vulnerable and unprotected being on the streets".

5.4.3 Dual/disorganised attachment style

In many instances, it was necessary to identify more than one style. This overlap of styles signified an overlap of components of both anxious and avoidant styles. For instance, the anger exhibited can also entail characteristics of ambivalence and/or fear of rejection (Fearful/Angry-dismissive style), whilst self-reliance and desire for company may

be rated as contradictory for some participants and fear of separation as non-standard (Withdrawn/enmeshed style). In those cases, more complex attachment styles may be observed (dual styles) [3]. Dual styles cannot be given for the mildly insecure or clearly secure categories, as they exhibit more complex forms of attachment (Bifulco et al., 2014). The dual classification is only considered for markedly or moderately insecure attachment styles. On the whole, precedence is given to the most generalised style first (primary style) and the other style is regarded as the subsidiary style. For instance, when features of avoidance are more pervasive than the desire for company, which might be manifested more superficially, then the primary style is considered to be withdrawn.

Within the sample, a high number of participants displayed conflicting attachment attitudes thus behaviours appeared to be confusing. For instance, a participant may present as clingy and dependent and at the same their attitude towards others may appear to be avoidant or fuelled with anger. Those pulls in both anxious and avoidant directions may indicate a severe instability, a difficulty to relate, an emotional dysregulation, and as previous research suggests a high risk for the development of psychopathology (Bifulco et al., 2014). Furthermore, literature (although limited) denotes a link between disorganised attachment and ACEs (see Green & Goldwyn, 2002; Beeney et al., 2017). Disorganised attachment is connected with 'unresolved trauma or loss'. In those times, prime caregivers may be a source of both comfort and threat. This impairs the child's capacity to develop a coherent strategy for managing feelings and experiences. This difficulty may persist in adulthood and incoherent working models may develop. As a result, confused approaches and/or avoidance may be sought in times of need. Attachment related fears, high anxiety and/or avoidance and disorganization were common features amongst participants with dual styles. Individuals that rated higher in anxiety exhibited a greater need for closeness in general, but when also had a dual style the fear and possibility of rejection interplayed and undermined their relationships.

Overall, the reporting style of those exhibiting dual/disorganised styles was often contradictory and incoherent, given the lack of integration and organization in the mental representation of self, others and relationships. A disorganised attachment style is uncommon amongst non-clinical populations and is usually overrepresented in clinically distressed samples (West et al., 2001). Considering the high rates of early life adversity and complex trauma within this sample, high rates of dual/disorganised patterns were somewhat expected. Conflicting anxious and avoidance strategies in interactions, as well as anxious approaches that correspond to both fears of abandonment and fears of rejection

were evident. In particular, a high number of participants displayed a general confusion about how to deal with relationships, high levels of anxiety, fear and hostility when around others. As a result, their relationship with services was also characterised by contradictory behaviours and emotional instability. This may entail a relating style that reflects a 'push and pull' attitude, dismissing approaches or feeling overwhelmed, hyperarousal, irritability and a hostile attitude when needs are not met.

In the following example, participants' narratives denoted the presence of both fearful or enmeshed and angry-dismissive styles. Fear of separation together with high mistrust and constraints on closeness co-existed with high levels of anger and high need for self-reliance. The first example refers to a 35 years-old male with a withdrawn/enmeshed style of relating. This participant scored low on the desire for closeness and high on the constraints on closeness, while self-reliance was rated as contradictory and fear of separation as non-standard. He identified his sister as his close other and although he had a dismissive attitude towards relationships, he exhibited contradictory self-reliance and fear of separation when separated from his sister or when he was not able to communicate with her. In relation to self-reliance, constraints on closeness and desire of company, he stated the following:

> "I can get on with anyone but I choose to be by myself sort of thing. I just feel that I am better on my own so I keep myself to myself. I feel a lot more comfortable. […] I feel safer by myself, so I know it's me and I stand on my own and nobody else is there. I just don't need any other people. I need to look myself first. I rely only on myself […] I don't confide to anyone, and even to my sister I don't speak about my problems […] I haven't been hurt because I have not been in that situation to get that sort of thing. When I was in a relationship, I was feeling down all the time, now I am back to my own self. I was always a loner. I can get on with people and staff but I just feel better like this". (Mark, 25)

However, when questioned about his relationship with his sister, Mark displayed an elevated fear of separation. In particular he said;

> "I rely on my sister a lot, when I am feeling low and that I know I could phone her and she will cheer me up. If she doesn't answer or call me back, I get stressed. […] It will be very hard if she wasn't there. It will be terrible if she wasn't there. I definitely feel worried, if my sister went away it will destroy me. Even if it was only for a couple of weeks but I would keep contact on the phone. But if it was for

longer, I would be destroyed. Just speaking to her and seeing her, I can't think this without her".

Another example is a 36 years-old male who was assessed as having an anxious attachment style, but was also characterised by avoidance of the anxiety around being rejected or let down by others. Daniel was assessed as having a Enmeshed/fearful style. This participant also displayed high anger, while he scored low on the self-reliance scale and high on the desire for closeness. He identified his partner as his close other and reflected on his reactions and beliefs around relationships as follows:

> "When things would happen, I would wake up and be in a mood. My partner may ask me and I will always say nothing and then I would use any reason to start an argument for me just to be able to walk out, clear my head and fight through this. It has always been barriers up and I wouldn't put my barriers down for no one, especially after I lost my wife. I was always saying to myself, I would never let anybody close again. […] I back off when I get too close, I feel that if I get too close to someone there is a bad atmosphere. I don't feel good doing it so I keep things to myself. I have been hurt too many times […] If she (partner) left me and met somebody else, I think that I won't be here. It is impossible to even imagine. When she is not there, I am feeling lost, I don't know what to do with myself. […] Yes I feel anxious (when partner goes away) because I don't know what she is doing, I don't trust her. For instance, she goes to the chemist and I know that it doesn't take too much time to be back and I am watching the clock and it starts getting late and I get more and more stressed".

5.5 Case study examples

To complement the above findings and describe in more detail the interplay of attachment style, previous trauma and engagement levels with services, two individual case studies are shared. These include a male and a female participant. The examples endeavour to demonstrate with greater accuracy the impact of personal and contextual challenges on the individual and their reasoning behind certain 'challenging' behaviours. The accounts below integrate diverse styles of attachment, place some emphasis on casual effects, and shed light on behaviours that may be considered 'typical' in front-line services. The selection was based on the fact that both participants are keen to engage with support but also ambivalent about the work and effort that this may necessitate. Furthermore, both participants had experienced prolonged periods of homelessness and rough sleeping, had

multiple layers of complexity and a difficult relationship with care. It is worth noting that the cases were not chosen with an eye on representativeness. On the contrary, the idiosyncratic aspects of each case are intrinsic in understanding the importance of personalised support, but also the varying histories and causal mechanisms that are likely to be observed in such a complex population.

Christy's story

Christy is 39 years old and she presents as very anxious when around others and when forming close relationships. She was assessed as having an enmeshed/fearful attachment style. Christy has been homeless for more than a year and she is currently staying in a B&B. She left home at the age of 16 and stayed with friends and partners for about 15 years. She first experienced homelessness at the age of 30 after fleeing from domestic violence. Christy had a history of complex trauma. She was physically, sexually and psychologically abused as a child. She was often emotionally and physically neglected when underage, while she grew up in a dysfunctional family.

She currently suffers from depression and anxiety and she has been recently diagnosed with PTSD. She has injected drugs from a young age and she occasionally consumes alcohol. It is evident that Christy has a prolonged history of emotional trauma and consequently a number of severe, interrelated and exceptionally complex problems which contributed to her homelessness. Much of this complexity is also rooted in experiences of violence and abuse in later life. She has been a victim of domestic violence a number of times and she has previously worked in the sex industry. The experiences of multiple stigmas and labels had a demoralising and debilitating impact on her.

Christy has no contact with her family and no close friends. She has a new partner but her relationship tends to be quite volatile and tense. She is not feeling supported or able to discuss her difficulties with him but she perceives being in a relationship as in some ways 'necessary' to survive on the streets. Christy said that she often finds herself jumping from one relationship to another as she finds it difficult being on her own. As a result, she often finds herself doing the same mistakes. She described herself as being 'easily led' and quite 'gullible'. Although her fear of rejection is quite prominent, Christy is prone to form relationships. Her primary style is characterised by high dependency on others, high desire for closeness and low self-reliance. Her relationships are fairly superficial, she does not trust others and she rarely asks for help. Her actual experiences of having been let down in the past have been generalised to fear of future interactions and desire to maintain a certain distance. The high desire for intimacy together with fear of getting close to others has led to loneliness. In her case her energetic attempts to achieve closeness combined with the lack of confidence results in developing relationships with partners that are unavailable to provide support and care (and at times abusive).

In all, her narrative was characterised by a deep sense of hopelessness and despair. This was also depicted in her relationship with services. Christy's relationship with care was characterised by ambivalence. Although she recognised her need for intensive support, at the same instance she was not feeling strong enough

Harry's story

Harry is 56 years old male and he was assessed as having a dual style of relating, where both anxious and avoidant elements are present. Harry has only recently secured temporary accommodation, while he has been homeless for more than 20 years. He has a history of complex trauma, as he was exposed to parental emotional and psychological neglect and physical abuse. His parents were divorced and he grew up with his father who was an alcoholic. Harry states that he suffers from depression and anxiety, while he uses alcohol to cope with the trauma-related symptoms.

> *My dad was a street-fighter, a trouble maker and we always got into fights and he brought us up tough, rough and basically the older you go the more he would hit you, we got battered and stuff so eventually when we got older we ran away from the house all the time. When I was 18, I got my first sentence. […] It is hard to explain, I am depressed and anxious with all the things I went through. I lose focus a lot, all my life been on drugs, it is still not out of my system. I am oversensitive.*

Harry identified his partner as his close other. The overall quality of the relationship was rated as offering inadequate support but no discord was identified. This is a long distance relationship in which they don't see each other often. Harry discussed that he does not confide to her most of his difficulties as she is not able to listen due to her own difficulties. His style of relating suggested that he has a great fear of separation and he tends to find it hard to get close to others or seek help. Overall, his answers were quite contradictory when the desire for company and self-reliance were discussed.

For instance, while he stated a number of times that he prefers his own company, when questioned more about it he said that he misses other people a lot and he wishes he could spent more time with his family and his partner. He displayed an intense fear of abandonment and an inability to cope with separation. Harry also exhibited a tendency to ruminate over negative thoughts and feelings, while his negative self-perception was further exacerbated by the fact that he does not feel understood, validated and cared for by his partner.

> *When she doesn't phone me, it is all in my mind. Even yesterday when she phoned me I was worried that she might not. It is a horrible feeling; it feels like you can't focus on anything else. If she was to go away, I would be greeting and I will be thinking that my life is finished and I would be devastated. […] Personally speaking I prefer living on my own. I can't relax with others around; it is not easy for me because I want to be on my own. […] I do miss people, I do want to see Mary more, I wish I could visit her more often. […] I feel like I need to get help, I need to sort my things out, I don't want to be in the jail or in the streets all the time. I do need support. I can't make it on my own. […] I cope well on my own, I don't ask others for help.*

In Harry's case the need for closeness and intimacy was also involving isolation and distancing. Yet, an intrinsic need to be supported and receive help was present. His difficulty in achieving closeness and seeking help interplayed in his ability to change his situation. Harry's feelings of powerlessness, low self-esteem and general poor mental health, as well as, his engagement in aberrant coping behaviours (e.g. use of drugs, other addictions), affected his responses to challenges and previous trauma. As he states, the traumatic experiences that he had to suffer are a recurring theme throughout his life. He has now started to work with a social worker but he finds it hard to fully engage and see himself as worthy of care. The past traumatic experiences not only deprived Harry of opportunities to develop a broader range of interpersonal behaviours and coping strategies, but compromised his personal agency in making decisions. It is worth noting that in his case what seemed as a free personal choice may have been unconsciously guided by unresolved chronic trauma.

> *Yes, relationships played a role (in becoming homeless). The way I look at it, it is my dad's fault for me running away from my house. It is my dad's fault that I had to go in an assessment centre. But then my dad can take so much blame. I am not saying that it is all his fault because obviously it is my fault too, because I chose my life. I always say if you suffered trauma as a child, part of you stays at the same age, that is the way I look at it. In a way if I had a different dad, I would be a different person. I wouldn't be sitting here today. I am not saying that everything is his fault but played a huge part in my life.*

Conclusion

This chapter has documented the descriptive characteristics of the participants and addressed the first research question of this project by providing a description of the attachment style profiles of the sample. It was hypothesised that attachment theory as a construct can assist in explaining the psychological and behavioural responses of individuals with experience of MEH. Those are considered to be critical to the relationship with care, staff members and services. However, it is not all down to insecure attachment styles. As noted in this chapter, the vast majority of participants had also a history of childhood abuse and drug addiction, which often links to higher levels of anxiety and hostility, chronic problems and difficulties in emotional regulation and interpersonal functioning. Thus, the ability of services and staff to provide appropriate responses to service users in distress necessitates amongst others, great awareness and training around issues of trauma and addiction along with skills in identifying attachment characteristics. The following chapters further explore the influence of attachment styles on client-staff interactions, as well as the relevance of the theory to understanding the causation of MEH. The significance of

attachment in designing and delivering service approaches will be also considered within the last analysis chapter where staff's emotional reactions are addressed.

Chapter 6: Attachment and Homelessness Causation Pathways

Introduction

This exploratory chapter focuses on answering the second research question of this project, which considers the role of attachment (if any) in the causation of MEH. Drawing upon the critical realist paradigm, the objective is to explore key generative mechanisms that may cause the phenomenon of homelessness to occur and the interrelationships that may develop between those mechanisms, the social actors and their relationship with context. In doing so, the theory of attachment is employed for enhancing our knowledge, understanding and interpretation of the issue under investigation. It is an exploratory chapter that does not offer any final or conclusive answers to the research question but it can be said that it lays the groundwork for future studies. Furthermore, the resonance between the data, emergent themes and attachment constructs which are explored can contribute to better understanding of the role of attachment in theories of homelessness. Emergent themes are primarily mapped on the attachment constructs in order to understand the meaning of the experiences for the actors who are involved and mechanisms influencing their circumstances. This chapter is structured according to three key themes that emerged from the analysis: 1) attachment trauma in context, 2) being psychologically and physiologically 'trapped', and 3) being socially 'trapped'.

6.1 Attachment trauma in context

The first theme focuses on the debilitating effects of past trauma that may have left participants more vulnerable to homelessness and less able to change their situation (prior to and post homelessness). Attachment trauma refers to the severe disruption of attachment relationships (in the context of a care giving relationship) that can affect individuals developmentally, psychologically and physiologically in early and later life. This relational trauma has adverse long-term impact on mental health, shapes relational behaviour and it can disadvantage individuals on many levels (i.e. adult somatization) (see Waldinger et al., 2006). As previously discussed (see chapter 3) research has been focused for years on the strong connections between childhood trauma and subsequent development of psychopathology. Evidence indicate that when disrupted attachments occur for prolonged periods of time, chronically elevated stress responses are established. The developing profile is thus of an adult that may not be able to regulate stress, struggles to trust and has enduring difficulties in forming social relationships.

Analysis indicated that early adversity and deprivation were particularly common within the study sample. As expected, trauma-related symptoms (i.e. anti-social behaviours, addictions, PTSD symptoms, depression etc.) in early and later life were routinely reported by participants. These and the related symptomatology somewhat predicated the presence of insecure, damaging, neglectful or broken attachments in participants' lives. Those complex patterns of attachment did not come as a surprise, considering that this was an extremely marginalised group that often circulated in and out of shelters, prisons and psychiatric institutions.

Drawing on participants' experiences of trauma and meanings they attach to those experiences, the impact of early adversity and its links to homelessness was further elucidated. Participants felt that their current actions were, at least in part, attributable to past adversities. The majority pointed to the role of early trauma in contributing to a pathway into drug misuse, poor mental health and at times into homelessness. For some the problematic relationships with family at first, and with partners at later stages, was considered to be the main factor contributing to their homelessness. However, for a few participants the link between severe trauma and current psychopathology was not obvious and they did not necessarily attribute negative outcomes to past adverse experiences. They rather suggested that substance misuse or even homelessness, were personal choices and past traumatic experiences did not account for those choices.

The following three quotations delineate the personal vulnerabilities and difficulties co-occuring with relational trauma. Gary had multiple and enduring mental and physical traumatic experiences. His ACE score was very high (ACE=8) and the consequences of trauma were evident in his narrative. Garry suffered from severe anxiety and depression and he was homeless for more than a decade. He communicated great difficulties in forming relationships due to issues of trust, fears of abandonment and anxieties when around others. He had used drugs for most of his life to cope with mental health-related difficulties and he had recently managed to come off his methadone script after several attempts. Gary stated that since he stopped using drugs, he experiences a different sense of self and gradually his clarity of mind is restoring. In relation to his experiences of attachment trauma, he explained:

> "I was ignored most of the time and then I started drinking when I was very young to stop it [sexual abuse]. I was generally getting battered for it. I wouldn't describe it as difficult at the time, but now I am an adult and I know this is not right. I

shouldn't have gone through all that crap. I shouldn't be drinking from a small age. I was drinking so my father wouldn't get drunk. Other times I would pour it down the sink or something like that and I was always trying to get rid of the drink. I was doing it when I was 9 to 12. I felt like I was always going to be a burden and I would be stuck for ever. I was thinking when I will grow up, when I will be big enough to put a stop to any of this. […] I was always slugged at school. I wasn't totally included; I was always on the verges if that makes sense. It is not always obvious what is wrong with you. I do wish I grew up differently […] I think my relationship with my parents played a role (to where I am now). It would have been different if you thought that you deserved it, if you have actually done something really bad".

Similarly, a female participant explained how her early life experiences shaped her character, behaviours and view of self and others. Ellen also disclosed a number of ACEs (n=8). As a child she was subjected to physical and emotional abuse and she often felt neglected and isolated. Her family environment was quite complex, with one parent using drugs and being in prison and the other suffering from mental health problems. In other words, her attachment figures were not reliably available and supportive, but rather abusive and neglectful. Exposure to a chronically stressed environment may most often lead to enduring patterns of insecure attachment. Ellen had a long history of rough sleeping since a young age. She is now in her early thirties and when questioned whether her relationships played a role in finding herself homeless, she stated:

"Yes. When I was 14 my dad gave me crack, cocaine for the first time. So that had a big impact on my life. And my dad being on drugs and hitting my mum and things like that…I thought that that was right so that had a big impact on me. That sort of made me. I can't really blame my dad because I could have said no to drugs but it made me who I am, it impacted to where I am now. I think relationships played a very important role. [...] Every relationship I was in was violent. I have been sexually assaulted, I have been beaten up by partners, I thought that it was right for a man to hit a woman, because I had it growing up and I thought that it is right. […] The first time I found myself homeless I was 16. I think my dad was in prison all my life and my mum, I don't know, I didn't really get on with her. I decided to move out, I couldn't stay with my mum, it was far too volatile. And then I ended up with houses and then I had my daughter and suffered from really bad postnatal depression. I couldn't bond with her, I didn't feel anything towards her and my

mum said that she will take care of her. After that I got into partying and more involved in drugs. I was about 18 when I had her. I couldn't keep a house down, I was too young to understand and because I had mental health problems from a really young age I didn't know how to look after myself, never mind a house and a baby".

Analysis suggested that the background stories of most participants shared many similarities with the examples above. What though differed was the emotional responses to stress and actual defences used to regulate distress. Participants opted for different strategies to cope with adversity based on their personal idiosyncratic characteristics and most importantly based on the actual behaviour of their caregivers. In theory, in the event that caregivers respond at times with love and care and others with anger or rejection, anxiety can be heightened. On the other hand, when caregivers respond with persistent rejection and neglect, then disengagement and avoidance can be heightened.

In the excerpt below, Patrick a 52-year-old male, discussed how his early traumatic experiences shaped his responses. This individual was exposed to chronic violence and he engaged in violent behaviours throughout his life. Based on the analysis of his interview, Patrick avoided getting close to others, he was a compulsive self-reliant and he exhibited high rates of anger. He was classified as having an angry-dismissive/fearful style of relating, however, he also appeared to have a strong fear of rejection. His relationships appeared to be superficial and volatile. He defensively avoided dependency and rejected offers of support.

"I have been in and out of drugs all my life. I have been in and out of prison all my life too. Violence was a big part of my life. That was all from a young age. My family is all violent, my uncle is violent, my dad too, so it was just what I was seeing from a little boy. […] I hated my dad, he was an alcoholic, he was a bully. He was physically violent. I always had to be the man even though I was a little boy. I grew up in a very volatile environment with volatile relationships with my parents and all that. It was just life and to be honest I didn't know any different life. […] Relationships was hard work, maybe this is why I am the way I am now I suppose. Why I don't get close to people because I was probably let down a lot when I was younger. […] What happens with me is I always put all my problems to the back and that is where a lot of violence comes from, because other people trigger everything that I have been trying to put back in my head all the time, it can be anything they may say. Why I am doing this, I don't know. I lost my daughter but I haven't spoken to anyone about that. I don't know why, maybe this is why I end

up taking drugs, maybe that is my cushion for that one. […] I have put it in the back of my mind because I don't want to deal with it. As far as I am concerned, I may have a sick mind because when I went to the funeral I just saw a box. In my mind this wasn't my daughter, this was just a box".

In the above example, the type of adversity in early stages appeared to strongly influence Patrick's responses in later life. He suffered physical abuse and neglect for prolonged periods. He also grew up with a father who was using substances on a regular base and a mother that was not always present. Patrick's increased reactivity to stressors as a child, his intensified feelings of insecurity and view of home as a dangerous place, shaped his coping strategies. He developed a defensive independence and a profound anger to deal with his emotions. As he stated he has tried to ignore his problems and quell his emotions throughout his life. These strong defences led to him becoming reluctant to express his needs to others and engage with services to find a resolution to his difficulties.

However, despite the high levels of hostility, avoidance and high self-dependency he exhibited, his frailty was also evident. In attachment terms, the experience of being aggressed against typically suggest a fragile ego far more than it does a strong and resilient one. Indeed, Patrick suffered from generalised anxiety and depression (as he stated) and he displayed a great inability to acknowledge his emotional need for others' support and care. In his view, he should always be able to deal with everything on his own and never require support from others. This view and behaviour contributed to a pathway of numerous episodes of imprisonment, addiction and eventually homelessness.

As chapter 3 pointed out, attachment trauma does not occur in a vacuum. In considering the role of attachment relations and trauma in the causation of homelessness, the possible moderating factors that may launch people with different attachment dispositions on pathways into MEH are considered. In that sense, environmental stressors, such as poverty, earlier illness and marital conflict further strain caregivers' ability to provide care. Whether those stressors constitute an independent burden when compared to the attachment-relevant stressors, mentioned in previous sections, is a question worth exploring. At the moment there is not enough evidence to conclude that attachment-related stress is independent of other environmental stressors (Gunnar et al., 2005). A degree of dependence seems to be present. Taking the example of poverty, although no direct links with the formation of insecure attachments can be postulated, a certain degree of influence can be asserted. Previous research supports the notion that poverty increases risk factors and possibly promotes harsh parenting conditions which in turn may create insecure attachments between a caregiver and a child (Wray, 2015).

Stronach (2011) suggested that the stress of deprivation and economic disadvantage when combined with abuse and/or maltreatment severely increases the risk for insecure attachments. Evidently, it has to be a combination of poverty with other stressors to reflect insecurity. Aligned with a critical realist perspective, the above example shows that poverty may increase the probability of developing insecure attachments in early life but the actual combination of poverty and potentially other environmental stressors and ACEs can cause the phenomenon to occur. Tharner's and colleagues' (2013) research suggested that children exposed to marital conflict, or those who had a mother with depression, showed high levels of stress only if they also had developed an unresolved/disorganised attachment. In other words, high levels of ACEs are internally related to insecurity in early years (multiple ACEs can predict high stress levels and insecurity on every almost occasion) (see Green & Goldwyn, 2002; Stovall-McClough et al., 2006; Anda et al., 2006; Waldinger et al., 2006). On the other hand, environmental stressors (i.e. poverty) may only have a tendency to cause insecurity. It is only when poverty is found in combination that the 'weight of the weighted possibility' substantially increases and predicts high distress and insecurity.

In terms of outcomes related to homelessness, previous research suggests a strong link between ACE and future homelessness (see Roos et al., 2013). However, those cross-sectional and retrospective findings cannot infer causation. In other words, outcomes related to homelessness and social exclusion cannot be readily attributed to ACEs only. Evidence points to a combination of causal mechanisms which interplay in a complex, open and non-linear way and can cause the phenomenon to occur. In this vein, this project supports the notion that it is the responses to ACEs and consequently the attachment style formed, along with the personal characteristics, that actually determine the coping mechanisms and relating capacities of individuals. In turn, depending on contextual factors those coping skills and relating styles determine the outcome in that the individual may or may not find themselves homeless. Each of the above components have its own causal power and degree of liability that may trigger, block or modify this outcome. The causal powers attributed to ACEs, attachment patterns and environmental stressors (besides their actual inter-relationships) can inherently limit one's capacity for resilience and healthy functioning. Evidently, those constraints could contribute on developing a pathway into aberrant forms of coping (e.g. substance misuse), a high degree of psychopathology or for some even to homelessness.

In this equation, it seemed appropriate to further consider the role of individual differences in stress responses. That is to say that some individuals may be more sensitive

to environmental and interpersonal threats and resources than others. Some individuals may undergo ACEs but may never experience the whole range of symptoms (or any at all), while others may develop disorganised patterns of attachment. It is highly likely that at least some difficulty will emerge in interpersonal relationships and patterns of attachment. This is almost unavoidable when cumulative risks are evidenced and protective factors are not evidenced. What though can make a difference and potentially minimise the risk are the kind of responses that the person has towards stress/adversity and the support network (e.g. other family members) around the person. It has been suggested that those elements can be a buffer for adversity and alleviate the effects of attachment-related stressors (see Hostinar et al., 2015; Liddell et al., 2018). In all insecure patterns of attachment, whether this is avoidant, resistant or anxious patterns are only moderate risks for psychological disturbance. It appears to be the intensity, type and duration of trauma, other environmental stressors and existing resources (which eventually shape the attachment style) that are actually influencing the outcome.

In a notable example, Donald scored 0 in the ACE scale. He stated that his father abandoned the family when he was young, and he did not get to see his mother as much as he wanted. However, those were not perceived, experienced or rated as early life adversities. Donald was diagnosed with PTSD after he had an accident in his forties. He is now 50 years old, he does not use any drugs or alcohol (now or in the past) for coping and he did not have any experiences of institutional care. It is apparent that Donald was not the typical participant. However, he was included in the final sample as he was rough sleeping for the past three years and he was not attempting to make a transition off the streets. He was rated as *moderately* withdrawn as he was able to form and maintain a relationship (with another service user), despite the fact that he was using deactivating strategies to maintain his distance. In his presentation he appeared confident and composed, while his narrative was factual, brief and precise.

Donald explained that his homelessness was linked to financial difficulties and family discord. These differed from the vast majority of participants whom had a more complex background and multiple causes of homelessness. Although it is not possible to make any firmly conclusive remarks using the above example, it is interesting noting the differences found in this individual compared to other participants. Donald stated that his inability to make a transition of the streets was related to his fear of failure and his negative self-perceptions. His actual style of relating and entrenched beliefs that only he can help himself, lead to him developing high defences, persistent self-reliance and rejection of support. As a result, he felt stuck in his situation and unable to cope with his PTSD

symptoms. Donald had never asked anyone for any help in regards to his mental health or homeless status. His family and any friends he had were unaware of his situation. As he stated he tends to isolate himself and never reach out to people for help, and he was averse to forming any close relationships. Donald has been using the shelters and some basic facilities for the past few years but he has rejected any bids for support in transitioning off the streets. He further stated:

> "When living on the streets there are no pressures. It doesn't bother me. I am sorry to be blunt but all these people that bleed and moan about whatever, hungry, homeless and poor. Well, poor possibly, hungry never. Not at least in this city and the homeless, the only reason that you are homeless is because you are unable or unwilling to get into accommodation. There is no point lying, people may say 'oh look at me, look at this'. I have got myself in this situation. Obviously I don't have any addictions issues so I couldn't comment on the people with addiction issues, drink, drugs or whatever. If you are just prepared to come in and get on with existing, there is no reason why you can't come in and just exist quietly and get on with your life. […] The first few times, it was a polite decline and then now because I have been here that long, they will ask occasionally and it is usually light hearted, 'if you need help you know we are here' which I understand and I appreciate and I do feel like petty sometimes when saying 'no, no, no' but as I said I do have reservations and fears about getting back into the old big bad world again. I am not ready. Mentally not ready to get back. I am scared, absolutely scared. It is easier to be under the radar".

In this example, high attachment avoidance when combined with severe levels of stress (i.e. PTSD symptoms) can result in the collapse of any psychological defences. Although no severe early life adversity was noted, his attachment pattern was quite inflexible. His personal characteristics, his defence mechanisms (including his response to later trauma) and his resulting poor mental health contributed to a pathway into homelessness. In his case, neither ACEs, substance misuse or prior environmental stressors (i.e. poverty) explained or predicted homelessness. What though it can be said with some certainty is that the avoidant attachment pattern which he developed did not allow him to effectively manage his distress and depend on others in times of need. In other words, his avoidant style of coping, along with his personal fears have partly contributed to and most certainly prolonged rough sleeping.

This example demonstrates most accurately that causal mechanisms are highly contingent and complex, and single changes in one level of reality (e.g. on the empirical levels) can bring about new and distinct outcomes in another. The range of quite separate causal routes into the same experience complicate findings and rejects any simplistic notions of social causation (see Bramley & Fitzpatrick, 2018). In reality and practise, ideas around necessity and sufficiency cannot be fully applied and provide an adequate explanation of this complex phenomenon. In this vein, it is more necessary than ever to favour a more blended approach in our explanation of homelessness (see Fitzpatrick et al., 2005; Bramley & Fitzpatrick, 2018). As shown above, the variety and changeability of social context may reflect multiple associations between causes and outcomes and in parallel it does necessitate openness to issues of potential fallibility.

It is noteworthy that although there appears to be a concentration of vulnerable individuals with often complex and multiple needs in the homeless population, who may have been exposed to adverse social and economic conditions, it cannot be said that those conditions always lead to homelessness. Poverty alone does not cause MEH in the UK for the simple fact that this entrenched type of homelessness is far more complex. In the same fashion, providing housing alone does not resolve issues around MEH for most individuals. Similarly, individual factors cannot also infer causality. The role of early adversity, the related coping styles and constructs of attachment are all contextually related. In this vein, attachment theory could potentially be a generative mechanism that could explain the link between personal factors and structural ones by emphasizing the need to place the person in context.

This section looked at a few plausible explanations on how attachment patterns and trauma can play a role in developing a pathway into MEH. An in depth analysis of those findings (by staying closer to the data) can be found in the next chapters. The feelings of entrapment evoked by adverse childhood experiences are only a small part of the effects of trauma on the individual. Its psychosocial impact is such that unless the individual is adequately supported and able to process it, she/he is 'entrapped' in acting and behaving in ways that may be deemed dysfunctional and lead to severely adverse outcomes. For some individuals this may even lead to homelessness.

6.2 Being psychologically 'trapped': Illicit substance use

Interviewees identified a number of other causal factors that could potentially cause homelessness or provide a trigger for subsequent mechanisms to be initiated. Amongst others, poor mental health, abusive relationships, substance misuse problems and experiences of institutional care were routinely reported. The findings suggested that psychological trauma and further crisis, abusive relationships and the use of illicit substances often resulted in creating a state of psychological and physiological entrapment for participants. At one level, traumatised individuals were not just more susceptible to re-traumatization but to the development of highly insecure attachment styles. As previously discussed, when attachment security is severely compromised for prolonged periods of time, engaging in dysfunctional ways of coping (e.g. substance misuse) is not uncommon. When this occurs, the possibilities of developing a positive support network that can be supportive and understanding are minimised. On the contrary, highly insecure individuals are often more liable in forming negative, dissatisfying and unsupportive relationships.

The high prevalence of illicit substance use amongst homeless individuals is well-reported. At the same instance, when insecure attachments styles are evident, the use of substances is also heightened (Borhani, 2013). During times of stress, highly insecure individuals may often resort in abusing substances as a coping mechanism. The higher the levels of insecurity the more vulnerable the individual in engaging in aberrant forms of coping (Molnar, 2010). The fact that illicit substance use may be linked to higher levels of insecurity, it does not necessarily determine the ultimate consequences; in this case this being homeless. As previously discussed, it is when this behaviour is found in combination with other factors such as poverty, ACEs, trauma and so on, that the probability of homeless is substantially increased. As expected, this does not happen in some predictable pattern but rather in a non-linear and dynamic way. For some participants, the use of substances in cases triggered homelessness and in others it was a coping strategy for surviving while on the streets.

However, for most (if not for all) participants, substances were a quick 'solution' to enduring and unprocessed post-traumatic symptoms, such as flashbacks and psychosomatic disorders. Although, this coping strategy was aiming to pause, numb and alleviate intense feelings of distress or distract the occupied mind, it also had deleterious health consequences. It is apparent though, that within the given context the conditions led to heightened use of substances. Participants scoring particularly high on the ACE scale, with insecure attachment patterns and experiencing a number of exclusions and social disadvantages were looking for an answer to their emotional pain, without necessarily predicting and reflecting how this response would affect them in the long term. From a

critical realist perspective, all individuals possess certain powers (i.e. can use substances) but not all have the tendency to materialise them. This very much depends on whether or not the conditions are right and whether the context allows for such behaviours. In turns, those actions may trigger subsequent mechanisms leading to completely different outcomes than were initially expected.

A strong theme within narratives was the idea that substances can ease the pain of their circumstances, can easily be accessed and provide a quick 'solution' to a complicated problem. In most cases, the psychological effects of previous trauma were such that the need for quick relief was great. Nonetheless, participants acknowledged that this strategy was not solving any of their difficulties in the long run. On the contrary, it was creating more barriers to their recovery. Although, it alleviated their distress temporarily, it adversely affected them over time. As a result, the reactivity to stressors was severely heightened, while physical and mental health were deteriorated dramatically. In all, avoidant coping styles, which often included the use of substances, took a toll on their ability to access care. In the extracts below, the triggers, effects and feelings around the use of illicit substances are further discussed. In particular, a number of participants reflected on how 'naïve', unaware and unprepared they were when they initially used substances. In a number of cases, the lack of awareness around addiction was related to outcomes. The quotations below are from two male participants, Patrick aged 52 and Mark 35 years old respectively.

> "At first I didn't know, I didn't know how to do it or anything, the time just disappears but before you know it you have a habit and you are addicted. You don't know what addiction is until you have it. […] I didn't know what habit was and what addiction was. I thought that I was taking that because I wanted to. I didn't realise. I went to prison in my twenties and that is when I start taking drugs. See, when I got out of prison that time, I didn't know what addiction to heroin was and I thought that I only had a cold. So I thought that I will just get over it and I didn't know. Then years later I was in prison again and I took heroin again and I said oh again I have a cold. And someone told me this is not a cold, you are clanking, it is the withdrawal from the lack of heroin. When I got some, then I was brand new again. I didn't know what I was doing. It was too late to stop. I was in that situation and I was knocking about with people and they were on drugs and I was on drugs. I suppose I could say I went with a clear conscience every day and night. I was going to steal to get my money or whatever and I didn't care, as long as I got what I wanted and that is the truth".

> "I have been using all my life. I feel like I lost my childhood and I don't know how to deal with a flat. When I was 15, I started using heroin. My mum kicked me out and I was talked into it from a guy I knew. […] Last time I was in rehab we talked about identifying feelings and how to cope with feelings. I was using heroin since a young age, so I wasn't able to identify them and I didn't know how to cope with them. I didn't know what it would happen. I started learning about some feelings. So small things, I can deal with but it is with some big-hearted, I just shut down and I end up using. As soon as something like this comes I just can't cope with it. […] When I was offered accommodation, I was too caught up in the addiction with the drugs. I was only interested in getting money for them. It's mentally and physically, they control you more than you control it. I can't think of the last time I had control of my life. I just lived day to day. For me it is the addiction that stops me (from moving out the streets). I have been coping like this for many years. I don't know any other way".

A number of other participants perceived the illicit substance use as a consequence of a free life choice. An example discussed previously, sets the stigma for what constitutes a free choice; *"When I was 14 my dad gave me crack, cocaine for the first time. […] I can't really blame my dad because I could have said no to drugs but it made me who I am, it impacted to where I am now"*. Along the same lines, participants often said that drug use is a choice and they are rightly suffering the consequences of their freely chosen actions. Scanlon and Adlam (cited in Dwyer, 2015, p. 21) noted that: *"Those who are scarred by poverty, abuse and neglect and social inequality are habitually deemed to be 'delinquent, deviant or offensive' and personally responsible for the dire situations, of their own making, in which they find themselves"*.

Whether using substances was a conscious choice or not is a topic worth exploring further in future studies. Trauma theory suggests that free will and choice can be compromised by the effects of trauma. In simple terms, when self is preoccupied with distressing thoughts and emotions, the ability to function in full capacity can be minimised. When those distressing thoughts are linked to severe trauma, one's choices and actions can be compromised. In other words, the actual taking of substances is an act of agency, albeit one tied to structural contexts (and often to emotional factors too) (Buchanan, 2004). However, how agency plays out differs depending on the context but also the options available within it the context it occurs (McNaughton, 2009). In other words, choice also involves the selection of the better present option. So the question should also be about which were the available options to those individuals? As previously argued, under certain

circumstances, substances have advantages (accessible, quick effect etc.) and may be perceived as the only viable, or at least most accessible and familiar, option for participants. Previous experiences of early life adversity may play an important factor in the action taken.

> "I was very close to my grandad and he died when I was 16. I was so devastated, I got really upset and that is when I first tried drugs. My mental health went downhill. The habit came later. It kind of started years ago, when my dad died. I was 19 at the time. I didn't have a habit until after my dad died. I used drugs before too but I didn't have an addiction at the time. I only used on occasion but it got worse and worse when other people died and I used this excuse to numb my pain. I was trying to cope but I am only saying it as an 'excuse'. Before when you go in meetings and that they always say what they use as excuses for using. But is wasn't an excuse, I was using to cope. […] I don't blame others; it was my choice. I have been in rehab twice. I had to come off the drugs and I went 10 times worse. It was the PTSD and I couldn't handle it. The drugs numbed me. I end up finding it too hard and when it was over I ended up relapsing". (Nick, 36 years old)

As critical realists would argue, it is crucial to take a person-in-context relational view. A degree of interpretation of personal processes and context is thus necessary to understand the meaning behind participants' actions. The link between traumatic experiences and substance use is well evident in literature (Zlotnick et al., 2004; Schindler et al., 2005; Chapman & Ford, 2008). As expected, in disadvantaged populations with high ACE scores, the risk for substance dependency is heightened. Indeed, participants often found themselves in situations (often within family environment) in which addiction-related behaviours were likely to occur. In addition, participants were highly traumatised which made them more liable to use avoidance coping strategies. Noticing the triggers for substance misuse within the sample, it was often obvious that they provided a sort of an 'antidote' to negative feelings and high distress. This mechanism is best explained by Salgado et al. (2007, p. 20-21) who argues that *"substance abuse itself can be seen as a dissociative response to trauma because it disrupts the integration of conscious thought, allowing for the avoidance of aversive memories".* However, it is only when coping skills were previously compromised, thus insecure attachments were established, that the risk appeared to severely increase for participants. For example, James (age 38) and George (age 39) respectively explained that:

"Heroin, crack, and benzos. I have been doing this for 20 years. My brother gave me heroin for first time. I didn't know what heroin was, I didn't know you could get this addiction and what it can do to your life. I have been in detox a lot of times but I messed it up. All I had was pain; you know you pick up that. The first thing you do you reach this bit of foil and pipe just to take that away. This was even more when I found myself in the streets, I was using the drugs more. […] You get the feeling that everything overwhelms you but see with taking heroin, it takes your problems away. But obviously they are still there. They are still in the back of your head you know. It will take your problems away for a couple of hours or whatever".

"I was sexually abused when I was a child. I was sent to care when I was 16 and I started taking drugs around that age. I didn't touch heroin; I was the last one to touch it. I was the very last person from all my pals. It blanks things out but a lot of people don't realise. When you wake up in the morning and you get all these flashbacks, you need to go again and find money and drugs and smoke it and then wait for the next time. […] Drugs were my only help, they shut my fears down. […] I think the drugs is causing the problems, I think most people that are on the streets are because of this exact reason, because of drugs".

In other words, the relationship between attachment and illicit substance use is very much mediated by negative attitudes about the self, including low self-esteem and depressive traits. Highly insecure attachment styles encompass negative attitudes and beliefs around self. In turn, individuals with those attitudes are much more likely to consume alcohol or use drugs as a way to cope with tension or anxiety. Nonetheless, it is the prolonged use and actual reliance on such coping strategies that mediate outcomes negatively. In the following quotations, participants explained part of their process for turning to substances. For some the attachment to drugs was such that it was dominating their narratives. For the few that had a set plan to come off the drugs when the interview took place, reflecting on previous states was particularly interesting. The following observations were shared by a female participant aged 29 years (Suzanne) and a male participant who was 44 years old (Gary) correspondingly.

"I started using heroin not long after I was 16. I met someone that was using it, and I thought that weed is not doing anything to me anymore. I am feeling upset even thinking about it now. [...] I have lost about 10 years of my life. I haven't seen the last 10 years. I have been in a pure bubble, I haven't even seen the world going by,

so I feel like I am seeing everything from a new set of eyes as well and clearer and I am still finding ways to cope with things other than use drugs".

"I was taking drugs for the biggest part of my life. Then I got put on a methadone script. I think methadone like drugs, it sedates your thinking, it takes the desperate out of you. It can give you psychosis without being aware of it. It numbs you. It is not that you are totally unaware of your feelings, it is just you are not as aware of them. I came off it about 2 years ago. My thinking is much clearer now. My emotions came back. I think it took me bit to get used to it at first… Now it feels that everything is more connected. […] If you were to ask me back then, I would have told you that it didn't really have that much of an effect on me. I didn't think before. Part it has to do that I didn't want to take the time to think either. It was too much and I couldn't cope differently […] When I went into rehab I had to deal with the reasons why I took drugs in the first place. It took me a whole year to remember that I was only 5 when I picked up a bottle at home. When you come back, that is when you really need some kind of help, some kind of psychologist or something to remind you how to stop being a victim and getting on with your life without making the same mistakes".

Psychological entrapment does not only refer to the avoidance and 'stuckness' stemming from past traumatic experiences (i.e. attachment trauma) and substance misuse. High insecurity and substance misuse are also contributing risk factors for the involvement in dysfunctional relationships and vice versa (this theme is closely explored within the next chapter). Engagement in relationships which can be unsupportive or abusive, and/or based on issues of co-dependency, can often proliferate feelings of powerlessness and unworthiness. In other words, increased emotional vulnerability, high distress and in cases the use of illicit substances are significant triggers for engaging in dysfunctional relationships. In this vein, feelings of psychological and emotional entrapment are again amplified and pose a significant barrier to recovery.

In summary, avoidant coping strategies are commonly used by individuals with enduring experiences of early trauma. When vulnerable, proneness to the psychological ramifications of trauma is inflated. This does not imply that individuals have a full knowledge of their behavioural processes and their consequences. In most cases, participants were 'drawn', 'ended up' or eventually 'found' themselves engaging in the compulsive comfort seeking behaviours of a drug or alcohol addiction; taking one action out of an array of negative options. It is evident that strong contextual factors and

problematic relationship dynamics can interplay in manifesting avoidant coping. Feelings of emotional, psychological and physiological entrapment appeared to be both the trigger for such behaviour, and the outcome. Individuals perceived themselves as being 'trapped' or stuck due to unprocessed trauma while young, while in later stages of life entrapment and stuckness resulted from addictions, abusive relationships and multiple exclusions. It appears that the reality of a highly traumatised individual with insecure attachments that grows up in an environment that poses chronic mild to moderate threat, is such that self-destructive processes are perceived as 'appropriate' responses; as a 'normal' reaction to adverse conditions.

6.3 Being socially 'trapped': External reality

This final theme refers to to experiences of being powerless, being institutionalized and eventually normalizing current circumstances, thus pointing to experiences of social exclusion and social entrapment. Attachment not only provides an emotional framework in relation to the view of self and others, but is also an important component in the development of a cognitive model of the world. General worldviews are also shaped by attachment experiences. According to Bowlby (1969, 1988), the differences in attachment styles signify differences in the views of what people are like, how they are likely to behave and why. Those internally developed processes form the external social reality, giving meaning to our perceptions of the world around us. Whether we perceive the world as a safe or a dangerous place and/or as a competitive jungle also depends on the subliminal or direct messages adopted through relating patterns. For instance, in their study Mikulincer and Shaver (2001) looked at the effects of the activation of attachment system on reactions to people belonging to an outgroup. The activation of a secure attachment scheme fostered a more tolerant view towards unfamiliarity and reduced negative reactions to outgroups. In contrast, the higher the attachment anxiety, the more negative reactions towards outgroups.

Evidently, attachment styles can influence social functioning and cognitive appraisals in a number of ways (see Torquati et al., 2004; Sheinbaum et al., 2015). The formed beliefs, expectations and meanings stemming from attachment relationships and trauma form a set of standards that guide behaviour and impact on the decision making processes (Stets et al., 2000). As personal and social identity is forming and attachment styles are establishing, individuals are more prone to engage in behaviours consistent to their beliefs, values and expectations of self and others. Attachment related concepts such as intensified negative affectivity, low perceived responsiveness of others, greater vigilance to threats, distancing strategies and lack of a secure base provide the foundation for the

development of negative generalized views of the social world. Whether individuals hold more positive or negative views when interpreting the unfolding events is basically determined by those beliefs and expectations. Processes around the formation of social and personal identity of homeless individuals is beyond the scope of this study. However, institutionalization and negative relations with authority were commonly reported experiences and appear to play a role in participants' interpretation and construction of social reality.

6.3.1 On being institutionalized

Institutionalization and imprisonment are forms of social exclusion which are causally related to homelessness and affected a great number of participants repeatedly. In detail, within this sample, almost two thirds of participants (n=17) had been subjected to imprisonment either for longer or shorter periods of time. A few have also left care prior of becoming homeless (n=8) and a smaller number have been previously admitted in adult psychiatric institutions (see chapter 5). Participants discussed how being institutionalised led to the development of certain regimes and practises, how normalisation of their current situation led to sustaining a homeless status, and how their engagement with formal authorities led to feelings of 'mutual' exclusion and disappointment. Considering that even a single event can have enduring effects on the cognitive appraisals of self and the world, a short discussion on the aforementioned topics is apposite.

From a psychological perspective, the adaptation to imprisonment is a very difficult and painful process. Although not everyone is affected in the same way, as this very much depends on a number of variables, incarceration can produce long-lasting effects. Being subjected to deprivation and to the extraordinary demands of prison life often translates into psychological harm and trauma. The atypical patterns and norms of prison life at the very least can bring subtle psychological changes in order to adopt to current conditions. This process of institutionalization demands adjusting to a regimented life and its practices. Thinking, feeling and acting are shaped and transformed by the institutional environment, while new norms are establishing. Haney (2001) argued that institutional transformation occurs in stages and is clearly associated with the length that someone is incarcerated. Nonetheless, he notes that when most people first enter prison *"they find that being forced to adapt to an often harsh and rigid institutional routine, deprived of privacy and liberty, and subjected to a diminished, stigmatized status and extremely sparse material conditions is stressful, unpleasant, and difficult"* (Haney, 2001, p. 6). In other words, institutionalization necessitates to a degree of transformation and individuals are often

subjected to a stigmatised status. Stigma and discrimination not only translates into social exclusion, but often the internalization of those experiences leads to feelings of social entrapment. It is thus not uncommon for those individuals to feel isolated and hopeless, reject and avoid offers of support, and eventually adopt a devalued identity.

> "I was always in and out of prison from since I was a kid. I was also in care but because I kept running away… so I ended up everybody abandoning me. I am now two days out of prison. I have been homeless on and off, in and out of hostels for all my life, for about 23 years. […] '*What keeps you in the streets?*' With me, my past shows that is authority. I don't like people telling me what to do, but now I grew up a bit older and I got my head screwed on. It is time for me to get on and move on. I have done all these for years, let somebody else do it. What I should be worrying about is me now". (Daniel, 36 years old)

On a different note, although local authority care during childhood differs altogether from the experiences of incarceration, it does constitute another form of institutionalization. Participants often discussed growing up in residential care and lacking stable, long-term relationships with consistent caregivers. Previous evidence indicated a number of adverse effects routinely experienced by children and teenagers in those environments. Amongst others those included: behavioural problems, attachment disorders, institutionalisation and difficulty forming and maintaining healthy relationships (Leve et al., 2012). The often high child to caregiver ratio, the lack of stability due to high staff rotation and on occasion poor staff training, are qualities often attributed to institutional care settings (Gheaus, 2011). Although social care may be an effective intervention under disadvantageous circumstances, the experience of institutionalization can also have lasting effects on many individuals. In attachment terms, the ecological context in which individuals reside, shapes the expectations of others as trustworthy or not, facilitate the adoption of certain norms and worldviews, and guide the construction of one's social identity.

> "I was a bad boy when I was young. My mum used to say you will go to care etc. but I never believed it. And one day I return home and my bags were packed and the social workers were there and they said that we are here to take you away. […] My mum picking the family over me and putting me in care and not having my parents around. I felt she chose me to go away, I felt like burning the house down. It did hurt me a lot. […] After what the social workers have done to me, what my

mum has done to me, that took me right off from trusting people. I wouldn't trust anyone". (George, 39 years old)

6.3.2 The issue of normalization and responses to authority

It has been previously argued that individuals' perceptions of their homeless identity depends on the length of time that they have been homeless (Snow & Anderson, 1993), that is, the longer the individual is homeless, the more likely they are to accept and adapt to this identity. As it progresses, the homeless identity is centralised and the likelihood of attempting to exit homelessness is decreased. This normalization of the living conditions impacts on the formation of certain beliefs and values. It creates a new reality and the person gradually adopts the role expectations (Snow et al., 1993). Participants narratives revealed that normalization of their situation perpetuated their experience of homelessness. William, a 56 years old participant has been in and out of homelessness since he was 16 and lived in temporary accommodation for the past two years. In the following extract, he was reflecting on the reasons that people may sustain those living conditions. He explained:

> "A lot of people in the streets don't want to get the help. I think it is because they are so used to being in that environment and there is a fear of changing your situation. If you are to go in a hostel or a house you are not used to it. You will probably go back to the streets again. It (street) kind of feels like your own environment after a while. I think mentally it takes a lot out of you because you are always tired, always hungry, and you know that nobody deserves to be like that. But you become used to it after a while. Sometimes it is just easier to lay in the streets. It is an easy way to make money and feed your drug or alcohol habit".

It is notable that the ability to adapt to a harsh and difficult environment such as the streets, is unrelated to the age of the first episode of homelessness. The need to adopt the group norms and engage in relevant behaviours is rather a matter of survival. Although such an adjustment may prove adaptive in the short term, it is increasingly damaging as it progresses. In many cases, it forms the beginning of what might be considered a chronic condition. The following extracts are from a male participant (Nick) who became homeless after the age of 30 and a female participant who has been rough sleeping since a young age (Ellen, 29 years old).

"People are getting used to living in the streets, they adopt and they are used to living that way of life and sometimes it becomes a habit in itself. In some ways this is what happened to me. As I said it becomes a way of life and it is hard to move into a house again and adopt to that again. You can hardly sleep on a bed because you are used to sleep on that hard floor. I have been in houses when I couldn't sleep on the bed, I had to lie on the floor. Living on the streets, it will become a part of your life and once you normalise it, you won't have the pressure to escape it". (Nick)

"…it is like being in prison all your life, you get institutionalised and you get used to being in that sort of routine. And being in a hostel, you are around people all the time and they are other people same as you that are drug addicts and it is just being surrounded by other people that are like you. I think this is why a lot of people cannot cope in a house. Because when you have a house, that is responsibility. That is exactly what is avoiding responsibility. In a hostel you don't have bills to worry about, your money is yours. If you are moving into a house you got council tax, gas electric…you have got everything. You have responsibility, in the streets you don't have responsibility. It is a different world". (Ellen).

Christian and Abrams (2003, p. 143) have argued that *"people that see themselves as 'homeless', and who identify with informal support services are likely to have a more clearly articulated antagonistic relationship with the institutional system and authority"* and *"are more likely to make use of the outreach services that allow them to survive without dependency on the institutional systems"*. It has been previously argued that homeless individuals are likely to feel socially trapped, rejected and disappointed by the government and formal authorities (Kennedy & Fitzpatrick, 2001). This appeared to be the case for some participants. Their engagement with institutional systems was often described in negative terms which often resulted in the rejection of formal authorities such as the law, police and policy makers. In particular, participants discussed how the 'system' often worked against them and did not promote social mobility and change. "*The system just doesn't work. There is always going to be this inequality between rich and poor. And the poorer you are the more difficult to find justice".* (Andrew, 52 years old).

It is understandable that within a particular social framework, the more someone attaches their own identity to exclusion and isolation, the more inclined they will be to construct beliefs that the institutional system does not work in their favour. It is worth noting that for those who had authority issues, their attitudes altered when they perceived

services as welcoming and non-threatening. Re-establishing trust on interpersonal, organizational and systemic level is necessary for facilitating social inclusion and access to services and care. As Allan explained:

> "Some people choose not to take the services because they feel like they have always been through the system. When younger through the social work…and they haven't got that much help from the system when they were younger so they think that everybody is the same. It is going to happen again. I have been through the system too. At first I was like 'these people are going to be against me' because of what I have been through. I thought that they will be the same like social work, so I was distrustful until I spoke to a staff who is an ex-user and this made a difference to me".

Although interviews did not explicitly explore ideas around institutional authority, a number of participants expressed their views on formal and informal services. In particular they assessed their role in finding themselves on the streets and having trouble exiting homelessness. The restrictions posed by B&Bs, the legislation on intentionality, and the rules within certain services were often mentioned as problematic. The following reflections from David and William are illustrative:

> "With the B&Bs you can be booked out at any point without any reason. You lose your accommodation because you are not allowed to talk to each other in the hallways. So all these restrictions and the rules and they throw you out for the silliest little things. If you are five minutes late coming in, if they see you talking to somebody, maybe talking to somebody giving you a roll up and they think that you are dealing and they chuck you out. People that have been on the streets, they haven't been living on rules so strict. […] People going to the services and they have all these rules, you are not allowed to sit and have a cup of tea, so we are meant to go back to the streets, sit about the streets, this is not good for you. When you go to the shelter and you have to get up at six in the morning and leave by seven you come straight here, there is nowhere else to go and they want to kick you out of here too. I can't understand it".

> "If you complain [in the B&B], there is no complaint procedures, they totally ignore you. When you are sort of homeless and stuff, you don't have the right, you don't have the same rights. I believe the rules are stricter. Not fully, but if you look at a lot of people that they are homeless, a lot of them can't sort of stick up for

themselves, so… […] Hands are right, because of your local authorities, laws, intentionally homeless and local connection. Which I feel, intentionally homeless, there is no such as thing. Why should anybody of sound mind become intentionally homeless? I was staying in a violent area, my house got broken into 3 times, I was assaulted and I gave my keys back after 3 years and I was intentionally homeless. They said we gave you a house that is reasonable to live. This is not the case; this intentionally homeless law is wrong".

Conclusion

This chapter draws on the second research question of the study that refers to whether adult attachment influences pathways into MEH. Data analysis suggested that attachment experiences and related behaviours can play a role and can be interpreted as increasing the 'weight of the weighted possibility' of homelessness. However, more research is required to robustly explore those associations before any definitive conclusions regarding the role of attachment in homelessness causation might be reached. The high majority of participants had experience severe levels of attachment trauma, often within their family environment (see ACEs), which remained unprocessed for prolonged periods of time and deteriorated by engaging in aberrant forms of coping. According to attachment theory, beliefs, attitudes and expectations about future interactions can be shaped by how individuals were treated by significant others across their lifespan. Once those developed, they can impact on the help-seeking processes, coping strategies and formation of relationships.

Previous evidence suggest that the vulnerabilities of highly avoidant and highly anxious individuals emerge primarily when they encounter negative external and relational events that they could not handle (over early years) or had the adequate support to handle. In turns, the ACEs foster the development of insecure models of attachment which in turn increase vulnerability and affect the ability to cope with stress. This increasing vulnerability (additional traumas, imprisonment, illicit substance uses etc.) can leave participants being in some ways emotionally 'entrapped' at early stages which can result to a progressive psychosocial decline and high distress in later life. It was evidenced across participants that substance misuse numbed temporarily and exacerbated in the long-term the psychological and emotional symptoms, whilst in parallel created new ones. Moreover, experiences of institutionalization (social care, imprisonment, psychiatric institutions) entailed a complex combination of social, physical, intellectual and emotional deprivation, that could eventually lead to a cycle of multiple social exclusions. In relation to this,

participants reported that poor mental health, substance misuse and other sociodemographic disadvantages were often moderating risk factors for involvement in the criminal justice system. Nonetheless, everything combined with lacking adequate support networks and appropriate trauma recovery, such that a sense of lost self and lost control developed and increasingly contributed to MEH.

Those states of emotional and psychosocial entrapment were evidenced across participants' narratives a priori and during experiencing homelessness. In this light, poor attachment experiences can form a key causal mechanism which can explain the process and conditions under which aberrant forms of coping and increased vulnerability can be developed and contributed in experiencing several forms of social exclusion, including homelessness. However, the conceptual framework, rooted in critical realist ontology, is developed through a synthesis of contextualised factors. In MEH populations profound early life stressors, related powerlessness and the lack of personal resources and support do not exist independently of social structures and the powers they possess. The general often 'negative' social environment (of poverty, dysfunctional households etc.) can be an indicative of participants' reality.

From a CR perspective, the connection between attachment and homelessness is more complex than simply generating a personal vulnerability and difficulty to 'overcome' trauma. Rather, the attachment experience interacts and interlinks with a number of other variables (trauma, view of self, view of the world, view of others, social context) which *"operate through an array of necessary (internal) and contingent (external) relationships"* (Fitzpatrick, 2005, p. 14). The objective of this chapter was to initially identify a compelling explanation but bearing in mind the contextual environment, social structures, connections and interdependencies between each component. For instance, personal choice and agency have often been 'blamed' as the main contributing personal factors to a pathway into homelessness. However, based on some participants' narratives it became evident that the idea that personal choice leads to homelessness is far too linear to be sufficient. Rather, within the range of options that structures enabled and the effects of severe adversity on the person, free choice appear to be compromised for participants. In other words, the complexity of the social world necessitates the integration of a number of plausible/possible explanations of the observed relationships. However, the inclusion of any causal mechanisms (i.e. attachment theory) cannot happen in a deterministic fashion. In open and ever-changing systems, theories and experiential findings are also treated as potentially fallible.

This chapter attempted to engage in exploring questions such as: Can attachment related concepts provide a framework that could help to explain why certain individuals may find themselves homeless? The analysis has made a modest attempt to delineate some attachment factors that have been neglected in previous studies of the causation of homelessness. However, the exploratory and flexible nature of this chapter, does now allow for any strong inferences to be made. Evidently, more research is needed in order to answer the research question under scrutiny. However, the chapter provides a starting point in order to develop a better understanding of the relationship of a number of factors, and primarily that of attachment insecurity, in the explanation of homelessness. In the following chapter, individual's motivations, actions and thoughts in relation to their homeless status are further explored. In this endeavour a thematic analysis based on the descriptive narratives of participants is carried out.

CHAPTER 7: Attachment styles and relationships with care, self and important others

Introduction

This chapter focuses on research question number three, that is; 'how do attachment styles influence relationships with staff members?' and it draws on the 30 interviews with people with experience of MEH. The chapter consists of three main sections, each relating to key themes that emerged from the analysis. The first of these is focused on the relationship with professionals and on social competence in more generic terms (i.e. existing support networks) given the finding that previous negative exchanges in social relationships with professionals and important others have shaped future interactions and impacted on the overall help-seeking processes and views of others as trustworthy and available to provide support. Following from this, the next sections offer an analysis of broader issues with regard to relationships (view of self and behavioural patterns) by way of explanation of participants' difficult relationship with care, for it is crucial to see the behaviour not in isolation but within the broader context that it emerges, paying particular attention on the emerging behavioural patterns and appraisal of self as worthy (or not) of support (see Bowlby, 1973). In particular, the second part looks at how participants portrayed themselves, noting how a negative view of self is associated with higher distress and greater difficulty connecting to and building relationships with others. The third section explores participants' patterns of behaviour and draws on attachment literature regarding the links between attachment-style dimensions and affect regulation strategies. Thus, it is focusses on the strategies and ways of thinking that each attachment style is more prone to embrace for alleviating distress and accessing support. The final concluding section further expands on the analysis by reflecting on why MEH individuals relate to professional support staff in the ways they do.

7.1 Social competency: View of others

In attachment terms, the working model of others refers to an individual's core beliefs and expectations of the availability and trustworthiness of close others. Analysis revealed that although the vast majority of participants were able to identify a close relationship with an important other, the quality of support that those close others provided was inadequate. In particular, most personal relationships were reported to be characterised by conditionality, unavailability and distrust. Notably, participants appeared to put more

trust in their relationships with professionals, but held an ambivalent stance on whether services can effectively address their needs. Building a relationship with a service was not a priority for most participants, who felt that service provision was often ill-equipped, with the level of input from mental health and addiction services being particularly low. This section will explore the levels of trust and support that these individuals have access to by paying attention to three major subthemes that emerged from participants' narratives. These include: views towards professionals, a lack of supportive networks, and participants' low perceived trust.

7.1.1 Views towards professionals

Considering the diversity and complexity of needs, participants were involved in complex patterns of care and received a combination of agencies' input over their life course. The role of professionals was deemed crucial in empowering and engaging individuals who have traditionally been perceived as 'hard to reach'. However, the relationship with care was often reported to be on a superficial level with participants not accepting at the core of the support that was offered. For instance, some individuals were accessing a front-line service on a daily basis, without engaging actively in any support work. Mainstream and specialised social support services were not deemed by participants to be able to fully understand or equipped to respond to the complexity of their needs.

To start with, trusting professionals, feeling safe and heard, emerged as a key theme in participants' narratives. For the majority, trust in professionals was perceived as resulting from the expectation that they are capable of acting and they will act in certain ways because of the formal position that they hold. Some interviewees highlighted professionals' obligation to adhere to good standards of practise, be biased-free and maintain confidentiality in order to create a base of trust. *"I trust one of the workers. I think because they are professionals they have to tell the truth; they can't lie"*. Nonetheless, strong emphasis was placed on the actual personal character of staff members, their degree of proactiveness and caring attitude when issues of trustworthiness emerged.

> "I am sure I can trust her, if she can help me she will do so. I was once at the shelters and she came and just said 'ok folk I am here. Who has a problem? I want to help somebody'. She knows what she is doing, she is direct and has offered me a lot of help". (Jenny)

Maintaining consistent relationships with dedicated key workers was described as pivotal for developing trust over time. In the absence of friends and family, service providers were at times perceived as the 'close others'; "*I would say they (staff members) are the closest family I would have. […] I am seeing them probably as much as…they probably see more of me than they do their families"* (Donald). However, when continuity of care was not provided, trust was broken while when staff were unavailable, engagement levels dropped. In other words, the degree of sensitivity and responsiveness on the part of staff towards highly complex individuals was associated with higher levels of constructive engagement. A female participant described her first experience of and response to a frontline service after having experience of severe domestic violence as follows:

> "After the attack, I went to get support. It was really hard that initial appointment and then the second one again I found it difficult and then in the third one they changed the worker, so I just found that the organization didn't get me. Because I find it so difficult to engage with the initial person, so changing it to another, it wasn't very nice. So I didn't go back". (Christy)

Although trust towards frontline providers was reported by the majority, overall levels of satisfaction with services were somewhat conflicting. "*Some of them are ok, but some of them are, just their heart isn't in it. Those ones I don't think they care, they just want their wage".* Low perceived others' responsiveness hindered seeking instrumental and emotional support. In a number of cases, participants' views and expectations were undermined by a history of neglect by providers, the absence of effective communication, active listening, and the perception that professionals were only relying on 'taught' knowledge.

> "Sometimes you get somebody and you can tell that they have learned everything from a book. Years ago when I started on a methadone, my worker used to say to me 'I know what addiction is like, I have a chocolate addiction'. But she has learnt everything she knew from a book and I am not much interested in talking to someone like that". (Daniel)

In attachment terms, individuals high on anxiety tend to seek more emotional support than avoidant ones when in need. However, they often perceive others as not been attentive to their signals/needs, supportive or understanding and they tend to feel dissatisfied with their relationships. A male participant with an anxious style of relating commented: *"Sometimes they do (understand his needs). Some people get to be treated*

better, I don't know why. I don't think the support is great, I think that they can be helping a lot more" (David). The tendency of participants scoring high on the anxiety scale to reactivate worries about others' availability and attentiveness appear to interplay in their relationships with support.

In contrast, avoidant individuals tend to be compulsively self-reliant in coping and believe that turning to others for help is not a helpful strategy. "*I have never really acted, being that close to the people in here (staff members) to put any sort of trust into them […] There is no service that can help me, if I don't want to help myself".* Their avoidant style of coping reflected an inability to depend on others when in need. Those types of behaviour were evident amongst participants when engaging with services. Furthermore, the fact that the majority of participants had a dual attachment style with a mix of avoidant and anxiety styles of relating, could partly explain their chaotic and often ambivalent stance towards professionals. In this example, Emma who had a dual attachment style responded in the following way when asked about her relationship with her support worker:

> "My worker was really good, I could tell her anything, I could trust her, she helped me a lot […] She did nothing for me, nothing really happened. I wanted to move because it was too far out for me. She would always say she would get back to me but never really did […] Sometimes I would engage but sometimes I won't but this is because she is never there […] She knows more things about me, I do trust her. She did more for me than my big sister did. I hope I can go back".

At times participants expressed their distrust of providers due to breaching of confidentiality, lack of sensitivity towards their mental health difficulties and addictions, and/or being let down on account of past experiences with services. *"No I don't trust them. I had a bad experience, when I shared in the past my very personal problems, after days every member of staff knew'* (Peter). However, individuals shared that their experiences within voluntary and low threshold services had been far more positive than had been the case with social services. In particular, several participants commented on their lack of trust towards specific professionals such as social workers and GPs. Participants attributed those concerns to their lack of involvement in treatment/programme decisions and that they were often provided with very little information or no explanation about their care plans. A female participant, Maggie, explained how high levels of engagement do not necessarily guarantee success:

> "I don't think I will get over that one. They (social workers) didn't let me know, they lied to me. I was meeting with them almost every day and I was doing everything that I was asked. They changed their decision, they were saying different things at first. In the end they said that it is better for my baby to go for adoption and from there I just spiral back down and I started using every day".

Perceptions that healthcare professionals are too busy to address the psychological needs and addiction difficulties were also barriers to seeking help. Some participants commented on how failures in providing social support and being solely interested in prescribing reinforced any reluctance to consult a GP.

> "They just write a prescription. I would never sit and work with a GP because I still feel that they are up to, from my past experiences, got there when I was 16 not even addicted to Valium yet, asking for it and getting it straight away. That is not right. I would never trust a GP; I would go there if I need to but even that. They are probably good for other people, but not for myself and when they have your records in front of them and they know you were on methadone you feel like they just still looking down at you, still judging you for been on a prescription or even when you are off it". (Ellen)

Although some participants acknowledged that frontline professionals seem to be competent and trained enough, the majority felt that staff often lacked knowledge about mental health issues and addictions. This is not a surprise considering that frontline homelessness services are primarily aiming on improving housing outcomes and applying harm reduction strategies. In other words, targeted training is not always a priority for low-threshold services.

> "Certain members here can deal with certain problems but not many things. In here you can see all sorts of different problems. I mean people that are using the service may have been actually sexually abused, or others that have been assaulted, or been tossed by their family etc. There are a lot of situations that a person may have gone through in services like this and I believe there should be a member of staff that can deal with people that may be highly traumatised. Maybe they need more training around those issues, so they have knowledge about it. Maybe each person can specialise in one thing, one in domestic other on abuse etc. I think this should be done. Because I don't think it's fair, because when people don't know about things like that they treat you different". (George)

In that sense, service users commented that their care needs were not met most of the time and expressed the view that services' responses were fragmented. *"They just fob me off with different support teams. It was just all different referrals which they didn't really understand what I was being referred for"*. To add to this, the lack of a continuum in care between service provision and accessing housing was at times creating a barrier to further engagement. Frontline services were viewed as a necessary but not sufficient step in making a transition of the streets.

> "Sometimes it feels, again nobody seems to give me what I need, it is just my experiences probably from the past. I think it is important when you are engaging with services but services don't engage with each other. So services aren't all aware of what is going on and you have to explain so many times, go back tomorrow and speak to someone different and they don't have a clue about anything of what is going on". (Christy)

In all, participants considered an ideal service to be capable of addressing all their needs. It is worth noting that factors affecting help-seeking processes such as the lack of professional expertise around mental health and addictions were mitigated by staff members' warm and caring attitudes. "*I feel as if now when I come in here, like a big massive thing has taken off my shoulders, I do feel safe and that staff is so lovely so it feels good being in here"*. When participants felt listened to and staff members were honest and positive about the future, trust was enhanced. Openness to more flexible approaches and joined-up approaches were particularly valued by participants and increased levels of engagement. As William who has been homeless for a number of years observed:

> "Staff make you want to come back, they treat you like a person, they don't look down on you. Even if one day you have been over the top, the next day I can come in and apologise and they give you this chance. They are on your side if you need help".

7.1.2 Lacking supportive networks

The second theme that emerged through the analysis of narratives referred to the frequency of negative interactions and lack of support in participants' interpersonal relationships. Through the interviews different tones emerged, often conveying contradictory feelings of confusion and disappointment resulting from their relationships with family, friends or partners. It is worth noting that the ability to reflect and make sense

of their experiences and others' responsiveness was at times impaired. For example: *"I don't share much. I think people have made their minds up before even listening to me. […] Sometimes it is even hard just speaking to someone. You are the first person that I have actually opened up to"* (Nick*)*.

The often complex lives relating to offending, histories of abuse and addictions undermined their relationships with close others which were often disrupted and problematic. The perceived available support from close others which was often limited and conditional, was somewhat indicative of relationship quality. Perceived responsiveness is a core feature of close and satisfying relationships. Those responsiveness processes referred to the degree that the individual felt listened to, understood and valued, but also to the extent to which close others have responded in a sympathetic and helpful way. Only a few (six out of 30) participants reported that they felt validated, understood and cared for by those that were identified as their important others. It is worth noting that those individuals had stopped using any substances prior to the study and they were making, or had made steps to transition off the streets. Overall, the majority of participants expressed feelings of disappointment and emotional and physical detachment from their close others. Those unsupportive responses often led to isolation and depression. *"I think sometimes she (partner) takes it in and sometimes I think she doesn't […] She looks like she is not really bothered about it, sometimes she can be very cold"*.

In the majority of cases, participants who were caught in a cycle of addiction identified other substance users as their close other (usually a partner or a friend) and occasionally a family member as their alternative other. As expected, effective communication, self-disclosure and responsiveness were at times compromised by issues of co-dependency. Participants who developed interpersonal relationships with other individuals that were actively using drugs often felt unsupported and not heard. *"It is hard for me to share but when I do, he (partner) basically does nothing, which is better. Because of his own things he is not always able to listen"*. It is very clear that substances influenced both the perception of responsiveness of others and the ability to respond in a caring and understanding way towards close others. *"I would speak to him but he would just get upset all the time. He is a really emotional person so he finds it hard to take things in"*. For some, the fear of burdening others and of perceiving others as not being able to understand their experiences were contributing factors in keeping themselves closed. As a result, their experience was silenced, often leaving them in a position where they feel unworthy and excluded.

> "If I was talking about something personal, he will bring up something up about himself and his past and he will turn it around to him. I just felt what is the point even talking or trying to open up anyway because when it gets turned around to him, he is not really interested". (Sarah)

A high number of participants identified family members, such as their mother or sibling, as their close other. Many participants described their family responses as harsh and resolute. *'My family doesn't want to do anything with me, because I am using drugs'*. Distancing from the substance user, setting boundaries and feeling unsure on how best to offer support were reported to be common responses by family members. Chris, a 38-year-old male who identified his mother as his close other described her reactions to his personal worries as follows:

> "She doesn't know what to say. All she says is that I should try to prove myself, try to get in a hostel or somewhere like that. I can share the positives with her. When things go wrong she doesn't listen, she may say - I don't want to talk about that".

Responses towards active substance users were reported to be commonly based on a philosophy of 'tough love'. Confrontational and/or cold responses by family members were often condemned by participants as they entail a profound misunderstanding of the nature of addiction itself. In an attempt to bring change and possibly help others, withdrawing, punishing and advising without taking into consideration the psychological symptoms of addiction were often dominating the responses towards active users. As a result, issues around substance misuse and homelessness were being avoided within discussions in the family setting. The struggle to articulate their experience and the conflicts often associated with it, left participants feeling misunderstood and dismissed.

> "It is not the best of responses. She (mother) usually tells me to pick up myself and do this and that, she doesn't do much listening or asking. Sometimes I feel as if I am talking to a brick wall. She is not having any understanding with drugs, she is a clear cut with these. She just says 'just stop taking them'. She doesn't realise all the stuff that got me there. I tried to explain to her that I have been taking drugs since I was 15 and before that I was staying with my step dad that was belting us for no reason and psychologically torturing us. He would insult us and won't pay attention to us. My mum just can't see it; she thinks this is not related". (Mark, 35 years old)

In other cases, participants did not actively confide much, even if the support was offered. This was a common trend amongst avoidant individuals who had a strong preference for self-reliance and expressed a discomfort with closeness. *"She (ex-partner) is the only person I can trust; I know that what I will tell her it will go no further. Personal things never come out though, they are all pushed away"* (Patrick). Participants with an angry-dismissive or a withdrawn style, appear to avoid intimacy and maintain emotional distance in their relationships. Personal self-disclosures were limited and participants appear to have low expectations for others' positive responsiveness. Peter commented; *"I don't think anyone owes you anything. […] I don't share because it doesn't change anything. She (partner) doesn't need to think about it, this will be a problem for her".*

In all, although positive qualities of interaction and support, such as being offered food and money and being able to share personal problems from time to time were identified, negative interactions predominated. Interestingly, although negative interactions were reported more regularly, participants felt that those responses were fair and appropriate. The interpersonal guilt and shame associated with drugs and street activities appeared to define and colour participants' perceptions of responsiveness and partly validate their experiences.

> "It is basically everything I went to my mum about, it is never good, it is always a problem. When I walk in she is like 'here she comes again'…I think she gets a bit fed-up of me […] I am thinking all the things I have put her through, I am really lucky that she is still talking to me". (Carole)

7.1.3 Perceived trust

In accordance with literature, the struggle to trust was an additional strong theme across this *markedly* insecure sample. Interpersonal trust provides the foundation for the development and maintenance of supportive and positive relationships. It encompasses general attitudes and beliefs about the degree that others may be available when in distress, or in daily-life situations. Those with a positive view of self tend to have a more positive attitude towards others (secure individuals), which helps them in developing trust and experiencing trustful relationships across time. On the other hand, individuals with insecure attachment styles are more likely to experience higher mistrust and be more suspicious of others' motives and behaviours. They often feel less secure in their relationships, which in turn means they tend to be less satisfying and potentially more

volatile. In all, when high levels of trust are experienced in relationships in early life, the ability to trust and create better-functioning relationships in later life is enhanced.

The vast majority of participants experienced a good deal of mistrust in their relationships which resulted in experiences of high insecurity and isolation. They often reported a somewhat 'paranoid' quality to their mistrust due to previous broken relationships and breach of their confidence. "*I am suspicious about everybody. Because they make up, they are your friends and always end up using you, abusing you or leaving you*". As expected, past traumatic events and the experience of homelessness severely undermined their psychological sense of trust and security. In the following comment, Robert describes the reasons underpinning his struggle to trust others:

> "Because of the things that happened to my life and things that I have seen, you know. I have tried to trust people, I have tried, I have tried my hardest to trust people, but they broke my trust you know. For a long time, I shut down the world who broken me, I am the only one left with the pain in the heart in the end. […] People break the trust and mess with your head. My mum lied to me and played with my head when I was young, so I can't forgive".

Being exposed to the conditions of homelessness for prolonged periods of time and lacking physical necessities that could bring a sense of comfort and safety had a debilitating effect on their ability to trust. In a sense, the external and internal reality were formed in parallel and gradually created a 'new' sense of self for adapting to the current expectations. "*One thing that this life (homelessness) brings you, is a complete lack of trust of everybody apart from those you sort of in contact if you like (referring to a close other). Because you can't trust anybody"* (Donald). For some participants, views that formulated in early life were upheld throughout the lifespan. "*I don't trust others, I was always keeping myself to myself, I have always been like this since I have been very young"* (Emma). In cases of severe distress in childhood, a negative view of others was maintained and interplayed in relationships in adulthood. George, a 39-year-old participant that had been sexually abused as a child, explained:

> "I trust others at arm's length. People are out for themselves, I just tell them what they want to know. I think it has been like this all my life, I had trust issues with certain people, I am trying to support myself on my own.

Nonetheless, perception and idea formation do not necessarily have a static quality across time. Prior positive views on interpersonal trust were in some cases transformed

after experiencing homelessness. However, the length of time that individuals were homeless seems to have played a critical role on this. "*Before (becoming homeless) I used to trust a lot of people, maybe I trusted too many people and they let me down that much that I keep my distances. Now, I have a barrier on, I wouldn't put my barriers down for no-one"* (Allan has been sleeping rough for the past three years). In particular, the length of time and number of episodes of homelessness impacted on their view of others as trustworthy or not. The longer individuals were homeless, the more likely they appeared to have a higher sense of distrust. This was often attributed to prior and post traumatic experiences and to the use of substances. Peter, whom had one of the lowest scores on the ACE scale (1 out of 10), described how he grew distrustful after being on the streets for a decade:

> "I don't trust people. I had quite a few bad experiences here and besides that when you live on the streets you start becoming more careful than before. Before (when not homeless) I used to trust people, a lot of trusting. On the streets things you may say can be used against you in the future. I used to trust people when I was younger. I used to think people are good by nature. I still believe it but not so strongly like before. I met on the streets really bad people, really bad. You feel safer when they know less about you".

In contrast, a few participants that have been homeless for shorter periods (less than a year) and did not consider homelessness as an important part of their identity but rather as a transitional phase, were less distrustful in their relationships. Although they mentioned their difficulties in maintaining trustful relationships, when asked about their general sense of trust towards others they had a moderate view. A young participant, Paul (aged 21) who had been rough sleeping on and off for about a year and had recently moved to temporary accommodation explained: "*I do give them the benefit of the doubt. I would trust someone on face value. I wouldn't say that it is hard (to trust)".*

For most participants, the difficulty to trust others was attributed to the broken confidences and dishonesty resulting from excessive use of drugs. High distrust towards active substance users was reported by both participants that were actively using and by non- or ex-users. A male in a co-dependent relationship stated: *"I can only tell her so much. I can't really talk to her about how I feel because she is the same, she has her own problems. I feel like I am burdening her".* Participants commented on how drugs were prioritised over everything else and often lead to relationships breakdowns. A female participant, Ellen, that has only recently came off the streets and is now on a methadone

script, discussed how interpersonal relationships are undermined by mistrust when drugs are involved:

> "You trust quite a lot when you are on drugs though because you think that everybody is your friend, you think that everybody that you are with is like your best pal you've got, because you're sharing your drugs. You look back now and you are thinking, this is not a proper friend, it is like a fake relationship, you are caught up with stuff, you are not your real selves".

Similarly, William who has been on the streets for a number of years reported:

> "I had a different lifestyle down there and I used to trust people. Drugs weren't much available down there, it was a quiet life. […] If it has to do with drugs, no I wouldn't trust anyone. All they are interested in if they are an addict, is what they can get off you to go and get their share".

As far as close relationships were concerned, in most cases participants could name at least one person as their close other (usually a partner or another person in a similar situation to them). However, when asked about their levels of confiding, trusting and intimacy, those were rated as being quite poor. Low levels of confiding were often attributed to the unavailability of others, low contact, issues of co-dependency and feelings of disappointment on accounts of broken trust. In addition, participants noted how hard it was to maintain relationships, in which they had a sense of belonging and feelings of connectedness when on the streets. Re-establishing trust with important others, required consistency and willingness to negotiate and create new grounds of mutual understanding. A participant that has been homeless for almost three years and identified his sister as his close other discussed:

> "Nobody knows that I am homeless. They [referring to parents and sister] all think that I am staying with a pal but I am not. […] it's me being stubborn. It is just those things that I don't speak to her (sister) about. I don't want to put pressure on her". (Mark)

In all, the association between insecure attachment and distrust, as well as prolonged homelessness and high suspicion was clear. However, it is hard to discern how specific attachment styles are associated with lower or higher levels of interpersonal trust in a homeless population. It can though be noted that issues of over-trusting that often implied naivety or gullibility, were reported far more often by participants with an anxious

relating style. *"I have trusted people over the years so much, and oh god, my trust may be gone but I still fall for people a lot"*. This is not surprising considering that attachment anxiety reflects a strong desire for closeness. On the other hand, attachment avoidant individuals, albeit that they did not draw on relationships for positive emotional support and confidence, held a more pragmatic stance towards distrust. They all reported a good deal of mistrust in their relationships, but it was not as intense or generalised when compared with individuals higher in attachment anxiety. *"I wouldn't say it is hard, I wouldn't put my full trust into anyone though [...] there is no point tiptoeing, if I trust someone and they let me down the I would just know not to trust them again"*. (Paul)

7.2 The portrayal of self: an internal reality

Drawing on the rich data that emerged through the ASI, this section explores three sub-themes related to self-appraisals, each of which illustrated different layers of one's feelings towards oneself, including: a cycle of hopelessness and low self-worth, personal constraints in forming relationships, and help-seeking processes. Several theorists have posited that perceived appraisals from others play a role in shaping the way individuals come to view themselves. Harris and Orth (2019, p. 2) for example contend that:

> Thus, bonds with all close others presumably signal to the self a generalized notion of one's worth as a person—that you are either valued for who you are from these stable, important people in your life, or you are not considered important from these people and are therefore an unworthy person.

In all, existing evidence suggests that social relationships matter for self-esteem and self-value over time. The reverse causal direction has also been evidenced in a number of studies. Those suggest that people's view of themselves (internal beliefs about worthiness of care projected onto beliefs about relationships) shapes the characteristics of their social relationships. (e.g. Erol & Orth, 2013; Myrray, Holmes & Collins, 2006). Self-views play an important role in understanding the world while also guiding behaviour. In attachment terms, positive mental representations of self, have been repeatedly linked with positive outcomes on different levels and tend to characterize secure individuals (see Mikulincer et al., 2007). On the other hand, a negative image of self is a distinguished feature of depression and low-self-esteem and is linked with high insecurity in attachment. Existing literature indicates that individuals that fall under the anxiety scale tend to have a negative image of self when compared with avoidant individuals who see themselves in a more

positive light (Mikulincer et al., 2007; Simpson et al., 2015). In dual styles of relating this tends to be more complex, with views towards self and others lacking consistency.

Furthermore, interviewees revealed multiple ways in which their experiences and circumstances were impacted by a status of homelessness. Being homeless and having a number of complex issues (traumas, addictions etc.), can heighten feelings of isolation, exclusion, self-blame and hopelessness. Amongst others, these experiences often led to developing negative self-appraisals which in turns were brought into their relationship with others and are deemed important to be further analysed.

7.2.1 Cycle of hopelessness and low self-worth

The term *learned helplessness* refers to a condition of being certain that your situation cannot change and you can no longer influence the course of your life. It encompasses a sense of hopelessness and diminished self-worth, and it can often lead to a state of depression (Goodman et al., 1991). This behaviour often is present in individuals that have suffered severe trauma and who tend to hold themselves responsible for their situation. Similarly, to the idea of *learned helplessness*, feelings of powerlessness and low self-worth were common amongst participants' accounts. Unprocessed complex trauma, mental illnesses and addiction issues were mentioned by the majority of participants as conditions that often led to experiencing feelings of unworthiness and self-blame. In this vein, most participants regardless their attachment style, expressed long-standing negativity about themselves and feeling of inability to change their situation, even when help was offered.

The concept of the 'vicious circle' of drugs, homelessness and abuse reflected a deep-rooted sense of hopelessness, self-blame and shame amongst participants. The cycle of relapsing or not being able to abstain from drug use was a dominating theme throughout people's lives and systematically influenced their perception of self-control and ability to receive care. Participants often saw themselves as victims of circumstances and felt deprived of agency. This sense of powerlessness and a lack of control, were often expressed by participants either in a direct way, *"I am a victim of my own life"* and *"I can't think of the last time that I had control over my life, I just live day to day"* (Robert), or indirectly, *"I don't know if I am that far gone. Sometimes I feel unsure, I feel that there is no hope for me, that is how bad I feel"* (Daniel). For some, the sense of powerlessness was linked with structural reality while for others personal circumstances left them feeling empty and unable to change the course of their life.

> "It makes me angry to know that there are empty buildings out there that I could stay, it makes me angry that this is happening, my life brought me here, things have happened for a reason, this is the life that I have been given, cards have been handed you know, so…". (Robert)

> "I couldn't stay in any place, I couldn't stand the noise, my main focus through my life was gambling, just gamble that was on my mind all the time so I couldn't stay in once place, I always had to do the same, so I was like who cares, I will stay at the streets and go back next week. It evolves into a circle. […] Sometimes I feel like I don't care for anything". (Gary)

For a female participant in her mid-thirties with a long-standing history of abuse and drug addiction, the vicious cycle of adversity had severely impacted her ability to change her situation. The sustained and repetitive nature of the abuse that Carole has suffered while on the streets left her feeling numbed and powerless. Experiences of victimization contributed to increased vulnerability for subsequent (re)victimization. This risk appeared to be further exacerbated when abuse in childhood was reported. For example, Carole (who scored 9 out of 10 on the ACE scale) commented:

> "I just feel empty, I feel like because I have been raped three times now, I feel I am just going to be raped again, it just feels like a constant repetition. […] I get close to people and I help them out and stuff like that but I don't know but it always ends up bad. Always end up me in a mess. […] it has been happening throughout my life".

Adults, as well as children, may develop strong bonds with people who have at times been abusive to them. An increased attachment is sought in the face of danger and threat. When support is not there, comfort can also be found in substances, which numb the mind and body and 'diminish' the symptoms of abuse and neglect. Phillip, who suffered abuse in childhood and adulthood, describes this pattern as follows:

> "[…] because folks don't realise they might get drugs and drink to forget that they were let's say abused, but say that is the reason that they started in the first place. Maybe they forget the reason but they kind of kept drinking or taking drugs is putting that exact same predicament, just making themselves again as vulnerable to strangers, as they were when they abused".

Indeed, in a number of cases the cycle of abuse was perpetuated throughout different stages of their lives, increasing the risk for further maltreatment. Early life adversity and addictions were factors that had often contributed to a cycle of hopelessness. A chain of traumatic events tended to reinforce certain behaviours leaving the person often feeling unworthy and hopeless. The following quotations demonstrate the mechanisms behind a continuous cycle of abuse for two women with complex trauma, which has increased their vulnerability and sense of worthlessness. The first is a reflection from a 30-year-old woman who has been homeless and using hard drugs since the age of 16. She has recently managed to stopped using drugs and she has been in a tenancy for the past eight months. Ellen described the reasons that she kept finding herself in abusive relationships, as follows:

> "I am always looking for acceptance because I was always in violent relationships, I always just wanted one that could love me I think (participant gets emotional). So I don't find it hard to trust. If somebody was nice to me, I was like they are a great person... […] I opened my life to everybody, I dropped all my barriers, I got shut every single time, I got really hurt".

Similarly, Christy a 40-year-old female with an extended history of domestic abuse and drug misuse commented:

> "A lot of times I feel that I am taken for granted. And again it makes me angry because I know I am not that stupid but… I keep making the same mistakes. Even if I know how someone is, I have been so gullible, so easily led, and I never want to think bad of someone even if I probably knew. I always end up hurting".

In the same vein, Phillip a 50-year-old male who has been rough sleeping for more than seven years discusses a cycle of abuse that he went through with his partner. Issues of co-dependency often emerged as a risk factor for elevating feelings of worthlessness and lack of control for both female and male participants.

> "It was like I was on a lead. Couldn't go anywhere. It felt like I was worthless, I couldn't do anything and I wasn't worth anything. This lasted for about 11 years […] She was a drug dealer. I was only there to do things for her and when I wasn't useful anymore then I was pushed on the side. Basically she threw me out of the house and I found myself homeless again".

For a number of participants, sustained alcohol and drug use was interlinked with feelings of shame and unworthiness. Self-hatred and shame appear to be core components of addiction in which an internalised sense of unworthiness often leads to feelings of despair and/or numbness. The comments below illustrate how shame reinforced the idea that oneself is inherently bad or that there is something 'wrong' with them. A long-term homeless chronic alcoholic commented:

> "I don't feel that I cope well with my problems. If it would have been a yes, then I wouldn't be here, so when I live in the streets, I still have a problem. The problem is alcohol and alcoholic thinking you know. This is the problem; it is a hard one because sometimes I think it doesn't make sense. Before when I used to drink and I was drinking a lot, I had no worries, I was thinking I have the time to make up for the lost one, to change everything. Now I think it doesn't make sense to change anything because it is too late. […] I had everything and I lost it and now I can't take some things back, it is too late for me. […] I think that most things that happened are 95% my fault". (Peter)

A deep–rooted sense of shame and worthlessness was also expressed by Robert, a 29 years old male that has been homeless for the past three years and also has a history of alcohol misuse. A sense of powerlessness and anger over his own actions was evident:

> "I just feel ashamed of myself, the drugs and the alcohol… I just went on and on. I get judged because I do drugs, I get judged because I drink you know, because I am a mad man […] it (alcohol) makes me feel comfortable, it makes me feel more myself. I find it hard sometimes even to go to a mirror and see this face. For the shame I have done, I shaved my hair bald, I didn't want to go and sit in a barber shop, in front of a barber to get my haircut, so I shaved it myself".

The difficulty to change and gain a sense of control over one's life was evident even when help was offered. On occasions, the difficulty to engage with services was attributed to the inability to cope with what may be coming up for service users when engaging with care. Feelings of hopelessness are often associated with previous trauma and exacerbated when past traumas resurfaced in order to process them. Christy had a community psychiatric nurse (CPN) that she considered to be helpful, however she still found it difficult to engage during times of distress:

> "I think you may be looking for something, an answer to something in particular, so you engage with certain services hoping, but… […] Sometimes I probably lie to him (refers to her CPN) about how I am feeling so I won't have to go. When I feel low, I don't want to deal with the outside world, it seems like an eternity walking down there, thinking who I will meet in the way, and then that feeling with my CPN, I just don't feel strong enough to deal with what is going to happen. I can feel really anxious and I really want to avoid what I am actually there for". (Christy)

The impact of early adversity and complex trauma can often leave people helpless in the present and overwhelm their capacity to cope when adequate support is not offered. The possibility of re-traumatization is also present. Understanding the dynamics and processes of trauma is central to the work with such a population. Mark, a 35 years old participant, describes his experience when he went into care in an early age:

> "Yes, is in the past I did work with a service, but I went off the rails after it. You (towards professionals) had to bring up stuff that I didn't want to bring up, like share stuff that I didn't want to share and I did and then I destroyed everything, fucked up, I went off the rail. When I shared it was always there after it, you know. I went at losing the plot, in 2015 I had a breakdown and that is why I am here".

Although powerlessness and a diminished self-worth was evident in the vast majority of interviews, a small number of participants did not seem to internalise their difficulties in the same way. On the contrary, they felt that they could influence the course of events in their lives. Those participants who were identified as having an avoidant style as a primary one seemed to maintain a sense of hope and a narrative that lessened the problem, or portrayed it as their personal choice: "*My life is my choice […] my problem (referring to homelessness) is not a permanent issue, it is a temporary issue. Tomorrow I can have a job and go back to the B&B. So I think it is not very difficult being not homeless"* (Jenny), or "*I am choosing the easiest way (being homeless) […] every day every time I can just take my passport from the safe, put my rucksack on my back, and I am free"* (Peter). Similarly, a third participant that scored very high on the avoidance scale and has been rough sleeping for the past three years commented; "*My current circumstances are due to my own ability as opposed to everybody else exterior doing something to me, it was personal choice […] I am not mentally ready to get back to the big bad world".* (Donald*)*

Drawing on the above examples, holding a positive view of self and being hopeful while rough sleeping or experiencing entrenched homelessness was quite infrequent. Issues

of addiction, past trauma and mental health difficulties associated with homelessness severely compromised their internal and external capacities to cope. Those experiences were strongly linked with a devalued sense of self and feelings of shame. The next section will further explore the psychological and also physical sense of isolation and exclusion associated with homelessness that affects the ability to form relationships with others.

7.2.2 Personal constraints in forming relationships

In identifying mechanisms of transfer that link attachment related behaviours and relationships with staff members, the constraints in forming relationships which develop naturally (referring to those that are not including only professionals) are pivotal. The constraints on closeness refer to the inability to confide and talk about personal issues and feelings to a close other, the fear of intimacy, the struggle to elicit care and support, and ultimately the difficulty to form a close relationship with important others. Attitudinal blockages which inhibit the development of supportive relationships were very common amongst participants. Those will be examined consecutively both in relation to the idea of self (the availability of participants) and in relation to how participants view others (the availability of others).

The ideas around self are linked with past social experiences and how a person thinks about the self in relation to those. Participants spoke about their relationships with others as being unfulfilling and unsupportive. For some this was attributed either to the use of drugs or to their homeless status. A female participant commented; *"I can't have a relationship, because any relationship I have at the minute is with drugs"* (Suzanne*),* whilst a male participant said; "*I don't feel I am in a stable enough place mentally or emotionally to deal with relationships"* (Donald). Relationships with others were often seen as important but also as unattainable. A number of participants commented on how high levels of anger and fear of intimacy played a role in keeping people at a distance.

> "I grew up on my own […] so I learnt to do everything on my own. […] when I am on my own nothing bad can happen. I am not a self-harmer but I know I can be dangerous to other people especially when I am drunk. That is why I try to avoid getting close to people". (David)

Behavioural responses in the form of withdrawal and avoidance and feelings of anxiety impact on relational functioning. In this highly traumatised sample, those effects were directly related to relational disruption. In many cases, individuals were unaware of

the reasons they feared relationships. For some, mental health difficulties were also heavily contributing to the ability to form and sustain stable and supportive relationships. Nick, a 35-year-old participant discussed how his poor mental health and PTSD symptoms ("*I am always thinking the worse and second-guessing their motives"*), prevents him from opening up to people and eliciting care: *"The fear that something may happen keeps me away from people and services"*. Past experiences formulated his current responses in relationships, and reflected how he feels following appraisals of self after traumatic experiences. He explained:

> "I had that many people dying on me, I feel as if I get too close to someone too much they are just going to die on me. I had two girlfriends and they both passed away and I feel as if it was my fault. Even when my dad had a work accident I still felt that it had something to do with me".

It was common for participants to attribute their concerns about relationships on past difficulties and distressing experiences either in early life or adulthood. *"It's hard being close to people. I think I was brought up this way. Like I wasn't that close to my mum or my dad, but I have never been that close to anybody. […] It can be scary, it makes me feel uncomfortable because I haven't been very close to others, if that makes sense"*. Similarly, a male participant that has been in and out of homelessness for more than a decade and experienced a number of ACEs noted: "*I am someone whose forms are ticked, when I was a child I was sexually abused by a certain adult"*, and described how forming relationships were mainly through alcohol (co-dependencies). When asked about his difficulties to get close to others, he stated:

> "I think I have developed in a way, that I keep a slight distance from myself and everybody. I would think it is some sort of protection. […] I think it is due to my childhood, basically we were always moving around with my father, I had quite an unsettled childhood, we always had a roof over our heads but we moved around so frequently. I do remember thinking once while I was still in primary school, what is the point being in school and making friends". (Michael)

> "All the relationships I have been in, they all have been drug users or were in and out of prison, so the emotions, me coping with emotions, arguments and things like that, it is not normal to me. […] I just haven't been in a normal relationship and I am trying to teach myself that this is normal, it is normal to argue and make up after instead of disappearing for days". (Suzanne)

In ascertaining the reasons for specific attitudes which an individual may have that form blockages in obtaining support and eventually creating distance from others, a number of psychological barriers were identified. Participants appeared to construct a narrative about themselves for integrating their various experiences and supporting their current self-views. As a consequence, they ascribed certain characteristics to themselves which impacted on the strength of attachment to others. A 30-year-old homeless individual commented when asked about his family: "*I am embarrassed to go and face all this, I don't want nobody to see me like this. Going back is not an option*" (Robert). Similarly, a chronically homeless individual commented: "*I think it has to do with self-confidence and with being homeless and dirty and stuff, I feel like I can't approach folk, it makes me feel on the verges and outskirts of society, I haven't really joined back in, I can't join back in until I can look normal"* (Gary). Negative attitudes towards their self-concept such as shame, low self-confidence and fear of rejection and intimacy, were common themes in their personal narratives.

In other cases, relationships mitigated some of the consequences of past trauma. However, only a minority of participants (six out of 30 participants), were able to form supportive relationships with important others at this stage of their lives. Interestingly, five of those participants were off drugs when the interview took place while one participant had started using drugs much later in her life (age 30) than most participants. For them, their perception of relationships differed from the majority in that they considered them as rewarding and necessary to sustain a life off the streets. *"If it wasn't for my dad right now I wouldn't be thinking getting a job and getting myself sorted. If it wasn't for him I would probably be in worst situation like in jail or something like that".* (Paul)

In those cases, participants were much more confident and often motivated to improve oneself. The mediating role of self-concept in terms of how a person sees and can describe oneself, permeates in all life experiences (Aron, 2003). In that sense, a positive self-concept could enhance the relationship quality. For instance, two female participants commented on how their ability to make and maintain relationships was sufficient to enable good levels of support and have at least one positive relationship in their lives:

> 'Do you feel you are good in making relationships and (if yes) in what ways?' "Yes, I like to keep people happy, be there for them, make sure that I say something positive and at the same time if people give me support, it makes me feel better and that". (Laura)

> "I am good actually. I can make mistakes or I could say the wrong thing but I am quite good at like making relationships back up and I am quite easy to make friends". (Maggie)

7.2.3 Help-seeking processes

The vast majority of participants found it very difficult to seek and ask for help. When asked whether they find it easy to ask for help if they had a problem, participants unanimously acknowledged that this was a struggle. For some the need to stand on their own feet was prioritised over asking for help, even when in genuine need. Although informal and formal support played a vital role in improving a complex situation, most participants opted to use private strategies to resolve their difficulties. Those strategies often included isolating oneself, using substances to cope, developing co-dependencies and/or regressing to violent behaviours when overly distressed. *"It can really hurt me when I don't get the help I need".* (Allan)

Unsurprisingly, a greater reluctance to seek help was identified for those that have been in and out of homelessness for a number of years. In those cases, it appeared that certain patterns of behaviour were already established and were less adaptable to change. An association between avoidance and prolonged periods of homeless was evident. For example, a highly avoidant individual that has been in and out of homelessness for about 23 years, and only recently has managed to come off drugs, commented in relation to help seeking:

> "I am always like this, I don't need your help, I will do it myself but my way of doing was bottling up, not talking to anyone. I will deal with it the way I want to deal with it. And my issue was, what takes this away; smack. Stubbornness more than anything else. I was thinking I can do it by myself, and it got to the stage where I realised that you know I can't do it myself". (Patrick)

Similarly, William a 49-year-old participant reported;

> "Sometimes I am scared to ask. I don't know why. Just because of what happened in my life I am just scared to ask people for help in case you get the answer no. I don't like the answer no. I won't be talking to them; I am off".

Participants identified a number of barriers for seeking support such as feelings of shame or denial, lack of trust in others, experiences of discomfort, and issues around pride.

"*Sometimes I can ask but most times I feel I am a burden to them, there are other people more important than me that need help"* (Daniel). Problems of communicating needs and emotional distress were resulting in becoming caught in a cycle of anxiety and avoidance. *"I find it hard because of my dyslexia. I find it hard to come in here (frontline service) and tell what I need" (*Allan*)*. At times, participants waited until severely distressed before seeking any support. *"I don't really go to them (GP services) unless I am near death's door sort of thing"* (Patrick). This behaviour was most evident when participants had avoidant traits.

> 'Do you ask find it easy to ask people for help?' "No I find it very hard, I never do. I don't know why, I just want to stand on my own two feet plus I don't want anybody coming up to me and saying 'well I have done this for you'. I better get back on my feet first, so I just rather deal with things myself". (Sarah)

> "It is hard for me. Just the way I have always been, I still think like this. I probably don't sort out my problems, because I don't ask anybody, probably (I) end up having the same problems for ages, I may ask advice, maybe…". (Daniel)

On the contrary, a few participants reported not having any trouble asking for help when needed. However, a more in-depth exploration revealed they did not opt for support in times of need. *"I wouldn't find it hard, but once again it is the sort of the same repeated scenarios, I would rather not ask than ask"* (Patrick). This behaviour was mainly attributed to feelings of pride in achieving and being autonomous.

As previously discussed, participants with an anxious relating style are characterised by ambivalence and/or desperation in their process of seeking support. In times of marked distress, highly anxious individuals may come across as coercive, indecisive or needy. When markedly insecure, their ability to access support from those around them is limited. In many cases, they may access a number of frontline services. However, in reality they seem to engage much less than their actual levels of attendance. In those cases, using the basic facilities of services was part of their daily routine, without necessarily taking any steps to make a transition off the streets. *"I have been coming here for the last one and a half years since I lost my flat, I use the service to have a shower and charge my phone, that's all"* (George). Similarly, a female participant, Sarah, commented:

> "I never thought about it too much (asking for help to get accommodated), I never asked them. I have just been too interested in going out and getting money and scoring and coming and having a shower and doing the same every day".

In most cases, their willingness to actually seek out and engage effectively with the service was impeded by their preoccupation with drugs. "*You have to fill the habit; it comes first before anything. […] the idea of getting help goes just out of the window. It isn't a matter of life or death"* (Thomas). Long-standing dependencies and lack of control of their drug use impacted on their motivation to use the available resources and left them with limited personal choice and agency. Besides motivation-related difficulties when accessing services, a few participants discussed how seeking support when having a set of complex issues can turn to a multistep process. This process can be particularly complicated and demanding, *"it is too much engagement, come and do this, come and do that…"*. It necessitates an awareness around the problem and being able to identify the appropriate and available resources.

> "I don't ask for help. I have been offered help but I feel that if I take that help is going to go against me. People will look at me different, which is a long way to go about it but this is the way I feel. I know I need some help I just don't know the right way of going about it. I am questioning whether I am asking the right people". (Maggie)

Finally, exploration of participants' narratives revealed a few gender differences in help seeking processes. Men more often than women reported negative attitudes towards help seeking and higher self-reliance to resolve their issues. They expressed a fear and a lack of control over disclosing personal information and a disbelief on the actual benefits of using services to change their circumstances. Cultural expectations and normative beliefs such as the idea that men should not depend on anyone for help and that they should be able to sort things only by themselves were reported by a small minority. On the other hand, women appeared to have a more accepting stance towards support. However, most female participants did not make full use of support offered due to previous negative experiences of services and drug-related issues.

7.3 Patterns of behaviour

This final section further explores participants' attachment dispositions and behavioural strategies when seeking support. The dimension of adult attachment is a critical individual-differences variable. As previously suggested, attachment related experiences and issues can predispose individuals to view others as reliable or indifferent and thus affects their use of social support (Wallace & Vaux, 1993). More specifically, participants' often very negative attachment experiences (i.e. previous rejection, losses etc.)

and their systematic failures in attaining security from a very early age, can signal the necessity for secondary strategies to be activated. Those secondary strategies refer to *hyperactivation* and *deactivation* strategies to regulating distress (see chapter 3).

As discussed in previous chapters, participants can be located in the two–dimensional anxiety and avoidance space. The interview scoring indicated that most participants (n=20) endorsed an anxious attachment style as their primary style and the remaining ones (n=10) adopted a primarily avoidant style. Nonetheless, the majority of participants met criteria to be rated as having a dual overall style as elements of more than one style were evident. The heightened insecurity of the sample allowed for discerning a clear view of their current strategies. The unique exploratory power of hyperactivation and deactivation strategies are further explored in this section.

7.3.1 Hyperactivation strategies

Hyperactivation strategies are a 'fight' type of response. When individuals are repeatedly exposed in an unsupportive, neglectful and insensitive environment particularly throughout childhood, self-regulation strategies are severely compromised (Shaver & Mikulincer, 2002). The unavailability of important others results in attachment insecurity. In anxious individuals this is manifested as hypervigilance and hypersensitivity to rejection and persistent worries about separation and abandonment. Initially, those behaviours are developed during negative interactions with non-responsive and unreliable attachment figures (Bowlby, 1969,1982). Gradually those strategies become the main regulatory device and overgeneralised in future experiences and relationships. In the long run, the individual relies on consistent and excessive attempts in achieving proximity with others in order to gain attention and support. At the interpersonal level, these individuals exhibit intensified demands for care, overdependence on relationships and clinging and controlling behaviours designed to elicit care. The implications were described as follows:

> "I don't trust anybody but at the same time I get really clingy and dependent to others, it has always been a bad thing, always. I always end up getting hurt. Because I tend to trust that person and I didn't trust anybody, so I get clingy to that person. It happens quite fast for me". (Carole)

Those dramatic attempts for closeness, sometimes result in negative interactions fuelled with anger and despair as attachment needs remained unmet. In addition, those demands for security can often impair the development of a healthy reciprocal relationship. Anxious individuals may take on a dependent and needy role, while they tend to regard

others as less responsive to and understanding of their needs. Their tendencies to ruminate and intensify fear-related responses often leads to intense reactions to any distressing situations. This can partly explain the challenging and frustrating behaviour often expressed by service users with an anxious attachment style when accessing services. In attachment terms, emotionally charged responses represent forms of 'protest' to extract care and attention and assure that the needs are met. A male participant that is a familiar face to most services and accesses a number of them on a daily basis explained that;

> "When I meet my GP, it feels like she is trying to get rid of me as soon as possible because I am a drug taker. I feel like I should be taken by face value. Sometimes I go off my head because of the way I get pulled over, it really bugs me and gets on my nerves when things are not explained through". (George)

A profound need for closeness and an intensified fear of abandonment was also expressed by highly anxious participants. For example, Wendy, a 37 years-old participant that has formed a relationship with another service user for a number of years explained how her fears of being rejected and being let down manifested in her relationships. At times, excessive worrying did not create a barrier in building relationships, rather an overdependence and an overreliance on a significant other to do things that can be done by oneself. To add to this, overdependence may result in creating relationships with others that are not always able to provide consistently responsive support when needed. Commonly, attachment figures could end up feeling drained by a person's endless demands for security and high mistrust. Wendy described her experiences as follows;

> "I always jump from one relationship to another. I am very clingy and I am very paranoid at times, I always think he is up to something because he tends to lie a lot. […] I can make up something up in my head and I can go around and round like that, it is horrible. For example, if he is late I can go mental. I go nuts and start screaming".
>
> 'Have you ever felt hurt or rejected by anyone you have been close to?' **"**Oh yeah, a good few times. I have regretted being open to people so many times, it has been happening all my life, the drugs played a big part. […] It seems like I often feel obliged to people and try to please them. When someone is giving me attention I am like a dog. I tend to call a lot of people friends, I just started assessing some of them out. I have got stricter and learnt to say no over the years".

Implications of increased dependency on others often included high anxiety, distress and anger when responsive support was not offered. Feelings of safety or security were compromised, resulting in the attachment system being chronically activated in an attempt to restore security. "*I think that for some people crying and shouting but not shouting at them, they might say that this is aggressive but to me it is just me hurting myself and crying and being confused"* (Christy). General dissatisfaction in relationships, feeling misunderstood and perceiving others as non-responsive to one's needs intensified existing negative affects and fears which created a cycle of further anxiety. A male participant that scored high on attachment anxiety further explained how his anxiety could intensify his fear-related responses and could fuel feelings of anger and despair.

> "If I don't get the support I need, I might get angry over it. It's been like this since I was a young laddie. I do come across like an angry person to the most, there are many things that can set me off. When someone is looking down at me, I start getting anxious and angry and I would have to leave the place. […] I think it has just been over the years, since I was young with all the things that happened and the lack of support". […] I hate my problems, I can think of them all the time, it can be stuck in my mind and I can't get rid of it no matter what I do. It goes on and on. (George)

Highly anxious individuals had a strong desire for closeness and intimacy, but also had a strong fear that their close others may abandon or reject them. In the following example, a female participant who has been in a series of abusive relationships commented; *"It (fear of rejection) does affect me in getting closer to people. You know how rejection feels, so you are scared that it will happen again and again. It has happened too many times"* (Christy). Even so, she has recently formed a new relationship that has also turned out to be abusive. Although relationship history in which significant others have been neglectful, insensitive or even abusive is further exacerbating the fear of rejection, for enmeshed individuals this does not necessarily create a barrier for forming new ones. Their persistent attempts for some closeness along with issues of unresolved traumas and addictions were interplaying in forming and maintaining relationships with people that were not often able to provide adequate support or alleviate their distress. On the contrary, in most cases they generated additional distress. A male participant, Michael, discussed an incident of severe abuse while being in a long-term relationship with a female alcoholic. In this example, proximity maintenance was prioritised over his physical and emotional well-being.

> "A lot of things have happened between us. I once had my head covered in scars because she got a couple of guys to beat me up. […] the following night, chap on the door and she is back and she is sorry. And she saw the state of me, I was black and blue, stiches and scars and then I stayed at her house for the next weeks. It makes me think into life that I should just get away from her but she is still very close. It's mad".

Besides proximity seeking, hyperactivation is also characterised by low self–reliance. Identifying the attachment styles of participants demonstrated that individuals high on attachment anxiety sought more support from others and had difficulty coping well on their own. *"Scott (partner) does everything for me. I am very dependent when it comes to making up my mind. There is a lot of things I wouldn't do unless Scott tells me to do so"* (Wendy). When asked if is important to be independent and whether they enjoy being so, the vast majority did not attribute any great significance to feelings of independency. *"I am not capable of being, I know I can't really do many things for myself"* (Nick). On the contrary, company, support and advice were prioritised. *"I can't stand on my own at all. It does bother me (being alone), I get really panicky"*. (Carole)

For some participants, emphasis was given to the difficulty of being on their own for short periods of time. Most commented that their tendency to ruminate over negative thoughts, feelings, potential or imagined threats was intensified when alone. Indeed, isolation can exacerbate negative affectivity. Daniel, a 36-year-old male participant commented; *"When I am on my own, I feel depressed, I just feel where do I go from here, how do I cope? I don't know what to do with myself, I am lost. It is very important to have people around me"*. Anxious individuals may often experience an unmanageable stream of negative thoughts to even minimal signs of threats, such as the example of being alone in a room for a few hours. "*Sometimes I feel like I can't breathe. I get something like a panic attack when alone. I start feeling anxious and I get short breath. I have 2-3 people that I know and I see them a lot"* (Nick). For some participants the hyperactivation of the attachment system did not solely reflect issues of low self-reliance but also fostered a negative image of self. *"It actually makes you feel useless that you need to rely on someone but I am not strong enough to be alone"* (Christy). The difficulty regulating negative emotions and self-relevant thoughts, entailed persistent distress and fuelled chronic worries and doubts about self and others. "*You just keep thinking of your past experiences, you constantly judge yourself. Quite a lot of self-blame"*. (George)

Overall, the high rates of insecurity and attachment anxiety within the sample highlighted the psychosocial vulnerability related to past and current relationships. At first

instance, hypervigilance to threats and endless demands for security are meant to ensure safety and survival. In adverse and stressful environments, those behaviours could be partly seen as adaptive. For example, they may appear to assist in surviving on the streets (i.e. being within groups). In reality they do not serve the purpose that were meant to, but rather they gradually lead to a feeling of being 'stuck'. Hyperactivating strategies can thus severely increase emotional and relational problems and create barriers to recovery. The detrimental 'side-effects' on interpersonal functioning are somewhat manifested within the sample. Furthermore, the strategies pursued by this group, such as clinginess, low self-reliance, hypersensitivity to threats and negative appraisals posed difficulties not only in the relationship with oneself and others, but also with care provision. Staff members may need to identify the specific ways individuals regulate and cope with their emotions and behaviours for supporting them in effective ways. Being available and sensitive to one's needs can often neutralise negative expectations by highly anxious individuals and create a base of trust and security. As one highly anxious individual said;

> "I need people to let me know what is happening. I want to be able to ask all the things that worry me. […] You need to have a worker that deals with some kind of difficult situations, working one to one. When people do come in (the service), someone may say to them 'let's have a wee chat, we can talk, I can talk to you, how are feeling today?' and so on". (Ian)

7.3.2 Deactivation strategies

As opposed to those scoring high on attachment anxiety, a smaller number of participants relied on deactivating strategies. Those behaviours tend to be manifest in a withdrawn or an angry-dismissive style. Deactivation strategies refer to the actual deactivation of the attachment system by disengaging from relationships or support and exhibiting excessive self-reliance. "*I don't want anyone close to me […] I don't know why, I just don't feel happy like that, I don't know what it's about"*. (Emma). These strategies include the denial of vulnerability and of attachment needs, defensively avoiding dependency and intimacy, downplaying threats and suppressing emotions, as well as a deep-seated distrust of others (Diamond et al., 2006). These negative core beliefs about relationships causes avoidant individuals to see others as intentionally controlling. At the same time, they are more likely to perceive that they are on their own and they can only depend on the self to handle any distress (Collins & Freeney, 2004). A male participant

with a primarily avoidant style, David, who has been homeless for a number of years explained:

> "I don't like asking people for help, generally. It is up to me to deal with my problems, and I always deal with them. Maybe it is just my point of view not seeking help. It didn't help me in the past. […] My father always used to say, no one will ever help you, you are the only one who can help yourself under any circumstances, whatever it takes. And I think this is me. […] I don't like to share my problems with anybody you know, I just push them down and hide them somewhere".

At the interpersonal level, avoidant individuals often perceive that turning to others for support is not a helpful strategy. Indeed, emotional interactions could be perceived as a source of threat. However, when faced with prolonged and distressing experiences, their tendency to suppress their emotions and attachment needs may often lead to a marked decline in functioning (Simpson & Rhodes, 2015). Their distancing in coping and problem solving, including their defensive stance towards threat-related thoughts and feelings, may only exacerbate existing problems. This difficulty to express their needs in combination with their perceptions around heightened (and often unrealistic) self-efficacy, may result in engaging in other forms of support for meeting their needs and easing their discomfort. In particular, when suppressed distress remains unresolved for prolonged periods of time, the ability to cope is compromised and psychological defences may collapse (Ein-Dor & Doron, 2015). Individuals high on attachment avoidance may further detach themselves from others, express high hostility and anger, develop anxiety disorders and control their moods by the use of substances.

Although their attempts to avoid vulnerability and being dependent on others assists them in restoring their sense of safety and independence, in the long run it creates barriers in establishing positive and supportive relationships. Those individuals often do not feel understood, validated or cared for, resulting in developing negative views of self and a wide range of psychopathological disorders. Their alienation from social networks and their distant, cold and pragmatic stance towards others and self, results in them being particularly reluctant to acknowledge their needs (or others' needs) for support and security. *"I cope well as long as I can put them (problems) in the back of my head. I put them aside and I just get on with things"*. Interestingly, their heightened autonomy seeking could often be mistaken for strength and personal stability. *"The way I was coping is by bottling up and just joking and putting a brave face on"*.

Deactivating strategies surface when important attachment figures have responded in a rejecting and neglectful way for prolonged periods of time (Bowlby, 1969/1982). In order for individuals to prevent the pain emerging from rejection and neglect, strategies such as defensively avoiding dependency and suppressing their needs for intimacy and comfort are activated. *"No, it is not important for me to have someone close to me. Why I don't get that close to people, because I was probably let down when I was younger. Maybe that is why I am the way I am now, I suppose"* (Emma, 40 years old*)*. Nonetheless, those attitudes go against the actual attachment behavioural system which motivates the individuals to alleviate distress in a socially based way.

It was not a surprise, then, that participants with an avoidant style often dismissed the importance of relationships and came across almost as non-emotional. *"It doesn't matter [if in company or alone]. It feels kind of the same. I don't mind one or the other"*. Their brief, factual and rational reporting style differed altogether from the highly emotional and often overwhelming style of anxious individuals. For instance, a 40 years old female when asked whether she feels she is good in making relationships, she responded; *"I don't know, I have no idea. I have never thought of this question. Sometimes I am struggling with people, I don't need people. Sometimes I have enough, I feel like - get out of my way"* (Jenny). Whilst another female when asked whether she finds it difficult to ask for help she said; *"I only rely to myself. Me, myself and I. I cope better on my own than someone helping me"* (Emma). When questioned about her emotional needs, she simply stated*; "No, I don't feel like that"*.

An avoidant style of relating represents a way of coping with an environment and attachment history that has been neglectful and insensitive to dependency needs (Freeney et al., 2015). The negative attitudes towards others and the defences emerging via the adoption of deactivating strategies led to feelings of loneliness, hostility and further detachment from others. The majority of participants with an avoidant style did not have a close relationship to turn to. Only a few could identify one but this again was characterised by emotional and often physical distance. As expected, in their relationships with services and staff members these deactivating strategies were also played out and in some ways defined the levels of commitment with services and portrayed their relationship with care.

In order to achieve optimal engagement and work effectively with services, avoidant individuals must adjust their autonomous desires and acknowledge their need for social support. In highly avoidant individuals, this somewhat goes against their own 'nature'. Thus staff members need to manage and respond in ways which 'break' those

cycles of withdrawal and disengagement. It may be that those individuals would require longer periods of time and higher consistency by staff for feeling safe enough to engage in support. Moreover, the majority of participants actually use both deactivating and hyperactiving strategies. As a result, a more disorganised and chaotic behaviour is manifested. This dualistic pattern of behaviour can often be unpredictable, making any interactions complex and hard to fully comprehend by services and staff members. Staff responses towards participants' deactivating and hyperactivating strategies are explored in detail in chapter 8.

7.4 Reflecting thoughts

It is evident that service users' attachment styles do shape the coping strategy they employ when relating to staff members. Moreover, they provide useful insights regarding their emotional regulation and help-seeking processes. However, other moderating factors such as the present environment, addiction issues, later trauma, idiosyncratic traits and early life factors (such as poverty and ACEs) also influenced service users' presenting behaviour. Those factors in some cases affected the relating style (e.g. early life experiences) and other times exacerbated or re-established the strategy in use (e.g. substance misuse). The combination and interaction of the above factors often resulted in 'chaotic' responses and erratic behaviours. It is worth noting that the role of each factor, its degree and nature is very much bound to the unique experiences of the individual, thus it is part of the responsibility of service agencies to discover the unique, contextually specific susceptibilities of those they support.

Initially, the environment that participants found themselves in is a critical influence on behaviour. Living on the streets not only conditions and shapes responses, but reinforces certain views and attitudes. Within this sample, the effects of the experience of homelessness in itself and the lack of security that this entails featured in all narratives. The conditions and the daily exposure to adversity can and do pose chronic mild to moderate and at times high threats for participants on different levels. Under such extreme conditions, the emotional reactions are increasingly heightened. *"I can't handle being on the streets, that is why I am hanging about with Stacey. It feels awful, I feel unsafe and I am terrified of it"* (Carole). As a result, normalization of the lifestyle is viewed as necessary for survival. *"It is like hard and comfortable, because I know all the things that you can do on the streets […] I feel safe in the streets"* (Mark). Normalization though of the situation also creates a barrier for change. For instance, a couple of participants commented

that moving off the streets was not a priority for them and they would opt for this lifestyle over and over again. In this vein, Peter and Michael discussed:

> "I think I miss a normal life but after a few times it begun to be boring for me. It is typical for all my pals in the streets. Everybody missed the normal life but after a couple of times, we start missing the streets. Somebody told me that after a couple of years of being on the streets, your mind has completely changed and I agree with it. For instance, a friend offered me a place to stay and said to me that I can stay as much as I want until I find a job etc. But I stayed there for a month and then I returned to the streets. I don't know why I missed it. I know it sounds crazy".

> "You put yourself in a situation of extreme danger, there is no security in the streets. The longer you live in the streets, the more affect it will have on your mental health, let alone the physical side, but you will eventually end up in a level where it will all become the norm to you and that is when you get numbed".

Closely related to context, a second moderating factor concerns the effects of any subsequent trauma that participants may have experienced while on the streets. Untreated symptoms of PTSD and/or prolonged psychological reactivity have long-term health consequences. For instance, poorly addressed complex trauma can lead to intensified feelings of negative affects (e.g. emotional breakdown, high distress), or to an emotional detachment and passivity (e.g. disassociation). As mental health is more and more compromised, the perception of self-control, the sense of safety, the ability to cope and form relationships with others are also fragmented. In such cases, the problematic use of alcohol and/or other drugs is an additional moderator often playing out in the relationship with self and others. Evidently, the majority of participants reported that filling their addiction was prioritised over anything else. As a participant said "*it is a matter of life or death*". The concepts of craving, compulsion and impaired control, which underlie addiction, impel participants to act in certain ways in order to restore 'normality'. *"You get the feeling that everything overwhelms you but see with taking heroin it takes your problems away for a couple of hours or whatever. It just makes me feel normal"*. When engaging in addictive behaviour, conflicting motives and erratic behaviours are more frequent. Those responses can create problems in interpersonal relationships, such as high distrust, disassociation from self and others, unclear thinking and so on.

Furthermore, as discussed in chapter 5, ACEs may also propel people with different attachment dispositions to adopt certain hyperactive or deactivating strategies. Those

dispositions could explain the help seeking processes or avoidance strategies that participants may use. For instance, participants who scored high on attachment anxiety maintained those feelings and appeared to be oversensitive to any threat, be that real or only perceived. Their tendency to regard others as less responsive and supportive to their needs, hindered their ability to access support, and in cases to alleviate their distress. In contrast, avoidant individuals tended to be highly self-reliant and dealt with difficulties without seeking help from others. Their deactivation processes often led to disengagement from intimacy and support.

Individuals that scored high on attachment anxiety were also more prone to experience extreme psychological distress upon traumatic events. These acute anxiety provoking events could instigate a number of anxiety disorders, such as PTSD, panic disorder and so on. In a sense, people high in attachment anxiety found it harder to rationalise and use distancing defences under such conditions. On the other hand, people exhibiting an avoidant pattern had a tendency to block and avoid rumination and used a number of psychological defences to 'ignore' the occurrence of trauma. Literature suggests that those individuals are less likely to experience PTSD under mild and moderate levels of distress but are more prone to experience depression and high self-criticism when those defences eventually collapse (Ein-Dor & Doron, 2015).

In other words, the pathways that each individual followed may have differed based on their attachment predisposition, however, when ACEs are prevalent, health and psychosocial outcomes tend to assimilate one another (e.g. high defences, heightened reactions etc.). In all, the intensity and nature of the traumatic event(s), as well as the personal characteristics influences the degree of impact, while trauma (un)processing defines the final outcome. When ACEs remained hidden and unprocessed, the effects on the individuals were unavoidable. In this light, it can be said that the abnormal levels of stress that this population experienced cannot lead to optimal social functioning. On the contrary, challenging and chaotic responses are to be expected, even if they appear to 'work against' one's actual needs. As Bloom (2002, p. 4) wrote about self- harm and other destructive behaviours; *'they are seen as normal responses to abnormal stress'*.

In order to understand and occasionally predict behavioural responses we presumably need to explore the formation of the reasons that individuals use for deciding or acting in a certain way. *"A rational choice is one that is based on reasons, irrespective of what these reason may be"* (Lupia, McCubbins & Popkin, 2000, p. 7). Whether participants are fully informed about all alternatives of each decision, the possibility of outcomes and their processing abilities are not compromised in any sense, is a question that

necessitates further empirical exploration. Bhashkar (1998 as cites in Lawson, 2002) refers to the *thin version of rationality* which refers to the pursuit of stable and ordered preferences (selfish, self-destructive or others) independently of other social actors. In other words, *thin rationality* supports the nation of an optimal way of thinking, processing and acting, where individuals are acting upon self-determination and preferences. In this sense, under certain conditions individuals may have a good reason to act in ways that may be seen as non-rational or arbitrary (McGee et al., 2013).

Conclusion

The main focus of this chapter was to explore the role of attachment styles in participants' relationship with staff members and provide an account of their narratives in relation to attachment processes as they unravel in adulthood. This exposition of attachment related behaviours, coping strategies, emotions and relational expectations is best discernible when the relationship with self and others is also scrutinised, thus an analysis of those elements was also carried out.

There was a consensus among participants that services were not well resourced/equipped to meet all their needs and they highlighted a profound lack of psychological interventions in particular. In turn, participants displayed little capacity to assertively seek out help when needed and thus be assisted by services. Trust was spoken of as a positive characteristic of the relationship with professionals, but it was acknowledged that this could be exceptionally difficult to build up, given participants' history of relationships and previous breaches of trust (within both personal and professional relationships).

Literature suggests that the actual engagement in proximity and support seeking is driven by individual-based strategies associated with attachment avoidance and attachment anxiety. The individual differences associated with each of these dimensions, and therefore attachment styles, were able to partly predict the appraisals of self and others, and thus the behaviour of participants. As expected, the more avoidant individuals engaged in deactivating strategies and the more anxious ones exhibited intensified demands of care. Although these predictions entail a degree of relativity due to the very nature of social agency, they do provide useful reflections on personal differences.

The chapter also briefly discussed the internal decision-making processes of participants, and reflected on their attempts to manage their individual life course within their context. Under certain conditions individuals may make 'non-rational' choices or choices which do not necessarily produce the best benefits. Participants may use

substances or prioritise this need over getting accommodated, in light of addictive behaviour, traumas and lack of social networks. In this respect, challenging behaviours may be understandable and potentially predictable if one takes account of the contextual nature of personal agency. In highly traumatised and multiple excluded populations, it is somewhat illogical for policy makers, service providers and occasionally professional support staff to expect a consistent behavioural pattern in the responses of service users. By acknowledging the intricacies of intentionality, motives, and present and past social context of service users, this study argues that focus can shift onto developing contextually and psychologically informed interventions.

Chapter 8: Cognitive and Emotional Responses of Staff Members

Introduction

This chapter focuses on research question number four, that is: what are the cognitive and emotional responses of staff members towards service users with insecure attachments? It draws on data from the four focus groups with front-line workers, which were aided by the use of vignettes corresponding to each attachment style. Those included: enmeshed, fearful, withdrawn and angry-dismissive (see chapter 5 & appendix I). It emphasizes how staff members make sense of the behavioural and emotional patterns of service users and how they are more likely to respond towards insecure and so-called 'challenging' behaviours on the part of members of the MEH population.

The chapter consists of three sections, each relating to key themes emerging during focus group analysis. The first relates directly to practitioners' responses to each vignette, and in particular their views, feelings and explanations regarding why each hypothetical individual may act and behave in those ways. The second section focuses on the practical techniques and approaches employed by staff when working with challenging individuals; some of which were deemed effective, others not. Finally, the last section explores two interlinked themes: (a) the role of staff members as the 'vehicle' for achieving optimal engagement with service users; and (b) issues relating to staff stress.

8.1 Practitioners' responses towards each attachment style

The four hypothetical scenarios were familiar to all participants, as they reported that they come across the challenging behaviours described in their daily work. As a result, the practitioners often related the cases presented in the vignette to their professional interactions with 'real' clients. The depth and analytic focus of each focus group differed slightly in that certain members engaged in more depth with the scenarios, while others exhibited a more generic stance towards each case. Overall, each scenario evoked a range of emotional and cognitive responses in staff members, providing rich data in relation to how service users' needs are understood and perceived in four low-threshold services.

8.1.1 Withdrawn attachment style

The first vignette referred to a female with a withdrawn style of relating. It was as follows;

"A female service user has a drug addiction and has been rough sleeping for 5 months. She is accessing homeless and crisis services almost on a daily basis to use basic facilities. She is always guarded and suspicious of others, and she does not really engage with staff members (e.g. makes minimal eye-contact), beyond small talk. Staff would describe her as always having a smile on her face and that she seems to know what she is doing and what she needs. In their interactions, it is observed that she will have a positive view on things and often minimises her problems. Staff try to offer support with her housing situation but she has now missed three appointments with the housing officers".

Key characteristics of this style, such as defensive self-reliance and high constraints on closeness (distant/cold stance, minimal contact), defined her presentation. Upon introduction of the vignette, focus group members were initially asked about their understanding of the way this client was relating to services. Participants reflected on potential motives behind the behaviour and described how they would be most likely to engage with a withdrawn individual. Overall, participants' perceptions were not strictly tied to a single position, however a number of commonalities were identified. The majority of staff members felt that this was a quite scared, distrustful and potentially highly traumatised individual that puts on a façade to hide deep-seated difficulties and complexities. They often felt that the presenting individual was in denial of both herself and the situation she was in, while diminishing her problems was a defence mechanism to cope and survive on the streets.

"It kind of says she is putting up a facade when she approaches the service. She is putting up a total facade, minimal eye contact, put a smile on, people think that I am coping, just do what you need to do and get out of here and nobody is asking me what is going on…people aren't getting too close. That is a difficult style because those clients can 'ghost out' easily". (participant 2, focus group 1)

"You get people that they present quite well, quite competent. And then slowly you realise that this is not the case at all. It is almost like a defence mechanism, it is how they keep themselves safe and how they keep themselves guarded. If you don't let anybody in they can't hurt you, that comes from being in a difficult home situation or if you are on the streets. If you don't let anybody past that barrier they can't really do any damage". (participant 1, focus group 2)

> "It is like the quiet kid in the corner, isn't it? Remember the book that came out, the people that get most attention at school are the kids that either really excel or the kids that noise everybody up. Where is the little kid in the corner who might be struggling, you know with the work of falling behind, or he has been bullied or whatever, but because they are not saying anything then they are kind of overlooked". (participant 1, focus group 1)

Some professionals interpreted the behaviour as cold and aloof, although for others it was clear that the behaviour was reflecting a protective stance. At times, the interference of defence mechanisms, such as denial and withdrawal, created the image of a resilient and autonomous person. Although, staff were able to acknowledge the individual's need for support the exhibiting behaviour was creating uncertainty: "*I would find it harder to work with her than with somebody who was in and has a burst of anger or some kind of emotion, she seems as if the emotions are so hacked in that is will be very hard"* (participant 4, focus group 1). Normalisation of her situation, illicit substance use and consequently diminishing the existing difficulties were seen as additional barriers for accessing the necessary care. The tendency to conceal and supress immediate needs left professionals feeling baffled about how best to support this client. "*This type of engagement of non-engagement*" led to debate regarding the best approach to 'interact' with this individual.

> "I think in a service like this (drop-in service), it's usually a very busy place and if someone is aware of the fact that I just smile and nod at the right time and say the right things at the right time, I look as much as someone else. If I look like I have got problems, they will come and try and help me. So I think it's also a bit of a learned behaviour, a coping mechanism on the client's part to keep a distance. She looks like she feels that she needs to keep her distances". (participant 1, focus group 2)

> "I would find it hard to work with her. In a situation like this it is a shame and all but it is also a shame for everyone. And the service is there, if that lady is prepared to take the help then hopefully she can. I know that if I can't help this lady, someone else would be able to help her. I think there is this thing as well accepting that if I cannot help someone, that is not the end of the world because chances are that she is going to respond a lot better to my colleagues". (participant 2, focus group 2)

When speculating about the reasons behind her actions, professionals asserted that the avoidance could be translated as reluctance to find a solution and change her situation,

or possibly interlinked with past trauma and/or mental health difficulties. Previous negative experiences of services, relatively low self-esteem and vigilant appraisal of others (as a result of rough sleeping) were also mentioned as plausible explanations of her avoidant behaviour. It is notable that drug abuse was not mentioned as a plausible explanation of avoidant behaviour. It is possible that with addictions being particularly high amongst service users, professionals were taking those for granted and/or were attempting to 'look past' those behaviours.

> "They might have had past trauma and maybe they have been through child services and foster care. So if they had a negative experience this is a reason that some may react in this way, males or females, previous abuse, physical, mental or emotional, makes it harder to engage with services". (participant 5, focus group 1)

> "This is probably similar to quite a few people that come to services and I think sometimes it can be overwhelming with all the staff. If you don't have one specific person that you can go to when there is so much stuff you don't want to say your story over too many times. I think this is possibly why some people would rather not say anything because they have told their stories so many times". (participant 5, focus group 2)

Defensive avoidance and high self-reliance were perceived as key barriers for engaging with services and making a transition off the streets. Staff perceived the possibilities to access support to be lower for individuals that do not vocalise their needs. Professionals felt that the presenting self-sufficiency and the fact that those service users actually ask for very little, will eventually make it harder for withdrawn individuals to engage in support. The risk of professionals colluding with avoidant coping patters, thus 'downplaying' the attachment needs of their service users, appeared to be high. This avoidance of further engagement may appear to be mutual at times, in that both parties may decide to sustain certain distances for a period of time. The reasoning behind those acts may differ, however. Professionals may 'neglect' service users' needs (or be disinterested) as long as those remain unexpressed, while withdrawn service users may be relieved when the focus of attention is not on them. Interestingly enough, for individuals high in attachment avoidance, being neglected or overlooked reconfirms their expectations and perceptions of others as uncaring and unreliable, thus this cycle of avoidance perpetuates.

> "A lot of people might go 'I can't engage with her' because it makes them feel uncomfortable because she doesn't want to talk to you. There are other females

that they will shout in your face and you know exactly what they want. It is kind of easier to work with them because it is obvious what you can do for them. Where when you got someone that is like a wall, there is nothing on it". (participant 2, focus group 2)

"I think that people like her often get missed because of the work and the clients that are more like 'I need help'. Because of staff shortage, people are going to the ones that they look like they are going to accept help so people like her sometimes are going through the net a wee bit, which is a shame just because they are not enough resources to speak to a client a bit more". (participant 5, focus group 2)

"I think that staff usually attend to people that are loud and complain, the ones that they are saying; 'you are not helping me!' The quiet ones that are struggling, they are not picked up right away…". (participant 4, focus group 1)

Results obtained in this vignette case indicated that gender, length of homelessness and to some extent age influenced the assessments made. For instance, staff members' approaches were occasionally influenced by the perceived greater psychological and social vulnerability of women as compared to men. In those cases, perhaps, a more differentiated stance was taken when support was offered. *"The situation in vignette one, I would say we see it more often in females. They need to create that sort of image to keep themselves safe on the streets. They have to put a front on to protect themselves"* (participant 2, focus group 4). Participants commented on gender norms and reflected on risks involved in being homeless, being a female and having a withdrawn style of relating. *"She seems very vulnerable. I think that's quite dangerous for a female when sleeping in the streets, they can be easily subject to threats and violence"* (participant 3, focus group 4). It is possible that interpretations and practices were shaped by service users' gender (at least in relation to reasons for non-engagement):

"I would say especially for women, engagement with support is harder. I think women find it more difficult and will kind of go a bit longer in trying on their own before they concede of what might see it as defeat; that they can't do it on their own anymore". (participant 1, focus group 4)

8.1.2 Angry-dismissive attachment style

The second vignette was of a 56 years-old male service user with a marked angry-dismissive style of relating:

> "A 56-year-old male who has been homeless for more than a decade. He is a familiar face to most services and is in and out of homeless hostels. He has previously lost his accommodation over drinking and antisocial behaviour. When asked about his housing situation, he states that he does not need any support or help with it. He will often have arguments with staff members and other professionals and has been excluded by a number of services due to behavioural issues. Staff members describe him as volatile, with poor impulse control, and consider him a 'loner'. When in a good mood, the client will often make jokes and laugh at things".

This style is differentiated from the withdrawn one on the basis that is characterised by angry avoidance of others. Expression of anger is the key trait. Other significant characteristics are high mistrust, a high need to have control over situations and extreme self-reliance. The discussions over this vignette shifted between explanations of the behaviour and staff members' previous experiences of similar cases. Professionals highlighted the difficulties working with a client with a hostile and highly dismissive attitude and discussed how they tend to handle those demands.

The transitions between the need for support, rejection, assertiveness and avoidance were seen as particularly challenging attitudes by staff. The often unstable, rapid changes of mood and behaviour traits of angry-dismissive individuals represented significant barriers for being able to engage and stay in relationship with those service users. Overall, the majority of staff signified those dismissing traits to be associated with experiences of repeated past rejection, fear of exposure, a deep-seated sense of hopelessness, and a chronic frustration related to the inability to change the situation. Additionally, the length of homelessness, alcohol misuse issues and the increased probability of previous exclusion from services were also mentioned as plausible explanations for service users' behaviour towards staff members.

> "I think he is terrified, it reminds me of one of my clients but behind this volatile behaviour, being loud, shouting and screaming and sacking and reinstating me, he was absolutely terrified. He was this little boy who never really…he was stuck at some point in his terrible childhood, he never grew up. A lot of this behaviour, I find when people are volatile and shouting and angry, it is because they are

absolutely petrified. They are so scared and they have never learned how to deal with things such as you have to wait for half an hour etc. Their response is I suppose rejection. I will reject you before I get rejected". (participant 3, focus group 2)

"When I first read it I thought god there is this real hopelessness. It is probably pure frustration about the situation they are in and not knowing a way out and not seeing a way out. Not know how to even attempt to get there because he has probably been through programmes after programmes, after rehab, and different services and different scenarios… I think a lot of our guys act out through pure frustration and not being able to actually verbalise how…I suppose is a cultural thing as well, not actually talk about your feelings and what is going on". (participant 3, focus group 3)

The internal interpersonal processes of angry-dismissive service users were particularly emphasised by staff members. What may appear to be a lack of vulnerability to some, was perceived as indicative of increased vulnerability and emotional immaturity by others. It was suggested that individuals who tend to exhibit hostile and dismissing attitudes were particularly vulnerable in times of psychological distress. In particular, staff members discussed how those individuals do not seek help when needed, but rather may approach services only when all other alternatives have been eliminated. Seeking support only when most at risk often compromised their recovery, especially when enduring mental health and addictions were present.

"I think a lot of the time the guys will shout for help when things are right at rock bottom and it tends to be a lot of health issues, you know when they know that there is something really not right here, this is probably the time where they reach out and we end up taking them up to hospital and then support in there and try and accommodate them from there. Sometimes it takes that crisis for them to actually engage, but having the trust in seeing you every day they know that they can go - Can you help me?" (participant 3, focus group 1)

Professionals commented on the functionality of anger and its role in providing alternative ways to attain one's motives under certain circumstances. They asserted that it is often a learned behaviour resulting from past trauma and rejection, but it also serves as a defence mechanism in relation to potential future trauma and threat. However, both unreasonably high hostility and the constant cycle of negativity that angry-dismissive individuals may found themselves in, are risk factors for future rejection, disapproval and

potential exclusion. In a sense, their expectation and belief that others will eventually reject them resulted in maintaining greater interpersonal distance from others, alienating themselves and consequently receiving less instrumental and emotional support when needed. Those expectations of being rejected by others again may have also lead individuals to behave in ways that confirms this supposition; often resulting in developing a vicious cycle of hopelessness.

> "I think that people are unable to expect care in a relationship. Because historically, possibly, this has been the relationship, that shouting, angry and volatile. So when somebody is trying to change this, it is not comfortable, it is different, it is not normal, I suppose. This is probably quite normal for them, that kind of behaviour. And I think that is pushing people away, it is constantly, constantly pushing people away". (participant 3, focus group 2)

> "It is a behaviour that you often see in initial stages. Sometimes this is just how you survive and how you cope, if you are to go to this hostel, you have to be a bit aggressive and antisocial to survive and stay away and not let anybody in again. Kind of being a loner is a defence". (participant 1, focus group 3)

> "Sometimes when people are being like that for a long time, they start to think that this is who they are, so they kind of cause the arguments, and it is kind of acceptable to them and just the way they feel all the time then; that it is normal when it is not really. It is like a self-fulling prophecy, when somebody has been told long enough that this is who you are, you start believing that". (participant 3, focus group 1)

Results further indicated that professionals were often translating the excessive anger as a form of communication of the attachment needs and associated the behaviour with early childhood trauma. Service users with highly insecure patterns were expected to form intense and volatile attachments to staff and services. *"In a way I see this as a form of engagement in itself, they still come out of their way to abuse you, it is more a translating issue"* (participant 1, focus group 3). Others explained the behaviour as resulting either from high distrust towards services which necessitated a period of 'testing' staff members, or from a great difficulty to regain control of their negative affect. For example:

> "It is like a child kind of behaviour, isn't it? It is a bit like a child that will push every button that you got and they will see what is the reaction that they are going to get. If you are still constantly going to be there, they begin to build up trust and

realise that you are still here, even though 'I did say x, y, z' and eventually the relationship builds on that". (participant 3, focus group 3)

"A lot of stuff that can cause issues are connected to instant gratification. When they come to the [name of service] they kind of want something but they want it right away. We are also supporting people at the night shelter and one day I was speaking to someone, and someone else came and wanted some help and I said 'give me two minutes', and he just left because we couldn't support him right in that moment. That is what I was talking about being highly sensitive". (participant 4, focus group 3)

Overall, the likelihood of being excluded by services was particularly high for angry-dismissive individuals. Literature suggests that dismissing attitudes have been associated with less compliance and commitment in engaging with support and treatment (Dozier 1990). At initial stages, following rules and regulations can be particularly challenging for those individuals. Access to services and housing can be restricted or removed when problematic behaviour or anti-social attitudes are present (Dwyer et al., 2015). As a consequence, the intimidating and hostile attitudes when combined with distancing and avoidant approaches posed significant barriers for developing and maintaining relationships with staff. Professionals reflected on the increased difficulty in engaging with those clients. When asked about their emotional responses they pointed towards feelings of exhaustion that could result in high levels of burnout. The approach taken was very much guided by those experiences: "*People think that they are challenging those clients by saying no. Well actually the biggest challenge it to be nice to them"* (participant 1, focus group 2). Overall, staff members when attempting to explain the behaviour were trying to see beyond the presenting behaviour. They mostly emphasised endogenous factors such as personal characteristics and motives in explaining their hostile behaviours:

"I think it is because they spent so much time on their own. They are not used to being with other people and they don't want anyone telling them what to do. If you go into a service there are obviously some lines that people may follow and if he has been so isolated and went through very rough times, he is used to this kind of life. And then, the alcohol affects a lot his personality". (participant 1, focus group 3)

> "I have met so many people that fit that profile. It is all about trust. […] Somebody that just normalised that kind of lifestyle. 56 years-old homeless, will probably involving homelessness the past 20-30 years, have been through most kind of services, possibly can't see a way out, has just became quite comfortable in his lifestyle. We kind of get situations where some of the guys we support because they have been in accommodation and there are rules and regulations that they can't deal with those rules, they just go 'I am not staying there' and then there is no places that the guys can stay". (participant 2, focus group 3)

8.1.3 Enmeshed attachment style

The third vignette looked at a 24-year-old, male service user with an enmeshed style of relating:

> "A 24-year-old homeless male, who after two years of living on the streets, has recently moved to temporary accommodation. The client is a heroin addict and has been diagnosed with depression. He does not make use of any services and was initially spotted and approached on outreach. The client says that he is fearful of others that make use of those services. After missing a number of appointments, the client has managed to attend the housing and GP appointments after regular prompting, but even then only when accompanied by a staff member. During appointments, he seems lost, overwhelmed, and scared. Staff members say that he seems very vulnerable and they will often spend a lot of time with him offering emotional support".

The description placed some emphasis on the fact that the service user appears to want to engage but his fears and anxieties when combined with systematic use of hard drugs and mental health problems are obstructing engagement. Key traits of the style were the high need for dependency and company, low self-reliance, and the absence of any constraints on closeness. Occasionally, anxiously attached individuals may also exhibit high ambivalence and a 'push-pull' in relationships, while at the extreme they can be incoherent and contradictory. Overall, enmeshed individuals are typically overwhelmed by their emotions and tend to exhibit low confidence in self and others.

The analysis of this vignette signified that there was a high degree of consensus in the staff members' perceptions of this style. Staff members discussed how they routinely come across individuals that tend to present and behave in such ways. They reported that

enmeshed individuals often initially appear to be easier to work with as they tend to be eager to respond positively towards support. In many cases, those individuals tend to be particularly keen to openly discuss their personal worries and difficulties with staff, while presenting themselves as needy and dependent. Staff members in general perceived the possibilities for those individuals to be able to handle the situation on their own to be particularly low. Their low self-esteem often resulted in social withdrawal, anxiety and emotional distress.

> "It sounds very mistrustful; anxiety would drip off him in waves. People like that they will tell you an awful lot in detail and it's a lot to take in sometimes. […] The most positive thing is that the person is engaging, where the other guys that we are discussing they didn't really engage. This guy is obviously wanting to work a bit more and that makes our job a wee bit manageable. They are open to engage with you and attend support even though there is a high level of support that is needed". (participant 1, focus group 3)

> "This type needs a bit more support, a detailed support plan, higher level of engagement and staff in place. On the negative side, they are usually desperate for help but at the same time it is hard to see progress with those ones. […] It sounds like a child in some ways, how would a child know where to go, how the child would know how to speak to somebody in a service. It is a service after all and it might be frightening. They are lost, overwhelmed and scared". (participant 3, focus group 4)

The exhibited vulnerability and high sensitivity, as well as the fact that enmeshed individuals tend to reach out for constant reassurance affected how their needs were interpreted. Their presenting fragility provoked analogous responses from staff. That is to say that staff members were more inclined to attend to the emotional needs of those individuals when compared with other attachment styles. Practitioners reported feeling more able to engage deeply and empathise with this type of behaviour than they did behaviours associated with avoidant styles. In their discussions, they often commented on the length of the support required by such individuals (i.e. *"That is a long piece of work"* or *"I have someone like this that I've supported for the last seven years"*) and questioned whether they may have inadvertently encouraged further dependency, rather than assisting the individual in developing ways of coping independently.

"When you get to know them better, you know their anxieties and you can pre-empt that and alleviate some of that stress with the hope that this builds confidence and later to do what it is theirs. You need to pay attention to the little things. […] For them it is always about not feeling that they are on their own. There is somebody there that is willing to help and be there". (participant 3, focus group 1)

"I have a client like this that he is quite needy and when he initially presents, he looks very vulnerable. He makes you feel you want to save him but you have to be really careful if you keep doing this. There is resentment and that kind of frustration after a while. Because there is still hopelessness and depression and they are still overwhelmed, and you are doing everything for them. I think you need to say at some point enough is enough". (participant 2, focus group 2)

Staff members' explanations when asked about their understandings of the causes of this behaviour were once more centered around past trauma. Additionally, young age and substance misuse were mentioned as significant risk factors for poor mental and physical health. The following reflection was particularly rich in illustrating how the formation of an insecure attachment in early life could impact on the social and emotional capacities in adulthood. As the following staff member explained, the powerlessness, the emotional turmoil and hopelessness are such that when no buffering factors could be identified (such as the sense of belonging and family support), the effects of early traumatic experiences can be detrimental in adulthood.

"Because what I have seen is with people, especially if there has been trauma in their past and they have started using drugs and harder drugs really early, just impacts on their brain development. I think as well when you think about our experience of growing up, I don't know about everybody in the room, I guess my experience of growing up I did have one parent that was very steady and very kind and loving and I think that stays with you even if you do go off the rails a bit which I did when I was a teenager for various reasons but you come back to yourself. Where people that don't have any positive influence or voice in their head, when things turn into chaos or there is really sort of difficult circumstances, and they are reaching in for that voice within themselves and there is nothing there. So people are just completely overwhelmed and completely lost because there is no learning and there is no teaching. It might be just really negative and boundaries that have been crossed and all the rest of it". (participant 2, focus group 1)

The focus groups discussions also indicated that the social characteristics of clients can have an impact on the staff members' perceptions of their behaviour. In particular, the practitioners related to the issue of young age when accessing support as an intrinsic characteristic associated with lower levels of engagement and higher vulnerability. The analysis showed that the age of the service user was important in relation to both the type of the approach taken but also provided insights into service users' support seeking processes and potential engagement. On the one hand, provision of more differentiated and well-adapted support was seen as necessary for younger service users. On the other hand, practitioners reflected on the higher level of difficulty in engaging younger clients when compared with older ones. Younger service users were often described as being in denial, more ambivalent about care, and/or considering themselves as invulnerable and self-reliant.

> "This one is quite young, which complicates things more. The older ones kind of get to the end of the road, they go 'I can't do this anymore, enough is enough'. They may have 20-30 years' experiences of homelessness and addictions and whatever else. While the younger ones they don't have the experience and the resilience but they are in denial, and they think that their lives won't turn out be like the 50-60 years old one's life. So they think they know the answers, and you know six months later they run up and their life is mess". (participant 4, focus group 3)

> "I think the younger ones are more kind of arrogant as well, they think they know everything and those things won't happen to them. That is kind of hard as well because you are trying to actually intervene at a crucial point in their life, they can go one way or another, and we have actually done this with service users. We spoke to people and said 'Listen you know to try and do this, sort it out and engage now because you can get caught in this' and it has happened really fast. They are going as if there is no danger and then you see them six months later in desperate states". (participant 2, focus group 3)

Overall, practitioners felt that there were only limited possibilities for enmeshed individuals to experience self-change on their own. Their relatively low self-esteem and the fact that they are typically overwhelmed by emotions and overly dependent on others indicated that they cannot cope well with distressing experiences, such as being on the streets or handle their problematic substance misuse on their own. Literature suggests that despite tending to present themselves as needy and ready to receive support, anxious individuals are not more compliant than avoidant ones (Dozier, 1990). Practitioners felt

that working with those clients necessitates gentleness, high attentiveness to their needs, consistency and patience. This entails the danger of staff members' feeling quickly exhausted. *"It is like keep pushing a rock over a hill, it keeps sliding back'* and *'It can be quite suffocating"*. However, as they tend to evoke feelings of compassion and sadness in staff more often than do avoidant individuals, the provision of support and attention is heightened. The difficulty though lies in setting clear boundaries, avoiding constant reassurance and using approaches that minimise focus on emotional distress.

> "I think the kind of enmeshed style can be as a worker maybe more emotionally exhausting than the other two (angry-dismissive and withdrawn). Because again mental health as most of the guys but there might be a lot of trying to second guess all the time or maybe trying to emotionally tap into somebody to kind of second guess what they are thinking and whether they are going to engage and so on. If I am with somebody all day that is extremely difficult, looking for you to emotionally support them it can be absolutely exhausting and you bounce off each other. I think people are likely to give up". (participant 4, focus group 1)

> "It can be frustrating as well when you know that they have the capacity to do certain stuff but they are letting you do them all the time. They know they can do some things themselves. I am thinking of a woman we had, she was creating each time a new problem just to keep me. It was like 'what she is going to call about next?' She has tried everything. I had this woman asking me to change the lamp for her". (participant 5, focus group 2)

8.1.4 Fearful attachment style

The fourth and final vignette refers to a 19-year-old male service user with a fearful style of relating. This attachment style avoids anxiety around being rejected or let down. It was as follows;

> "The client is a 19-year-old homeless male diagnosed with bi-polar disorder. He was adopted at an early age, experienced physical abuse, and in his early teens was transferred to another family. After an argument with his foster parents he left home, sofa surfed for some time and ended up in the streets. He uses crisis services very rarely and when he does he is visibly distressed. He uses drugs to self-medicate. For a period of time, he started engaging more with staff and making progress toward resolving his housing situation. During this phase he was described as being open

to discuss his difficulties, but also 'shaky' and kind of frightened when doing so. He then disappeared for more than a month and when he re-appeared, he had a number of wounds possibly resulting from self-harm. He denies self-harm and when asked about the incident he says that this is what he is like".

In most cases, the presenting fear is related to past, traumatic and disappointing experiences which have later generalised to fear of any future interactions. In this hypothetical scenario, there was an indication of a high desire to be close to others, coupled with a fear of doing so. As a result, the service user disappeared for prolonged periods of time and when in high distress reappeared and re-engaged with support. In addition, there was a high tendency to self-blame and attribute most failures to oneself. Overall, mistrust, fear of rejection and constraints on closeness were high due to lack of faith in self-worth and self-efficacy.

The analysis showed that practitioners primarily focused on service user's fear of engagement in the face of a potential disappointment. The difficulty in supporting her lay in providing care with consistency without 'scaring off' the service user. Practitioners discussed that in many cases those individuals have trouble believing that there is someone that may care for them and they tend to disengage when the relationship gets more intimate. Premature disengagement in such cases was either attributed to service users' personal fears around relationships, or to substance misuse problems. Sometimes service users' ambivalence and approach-avoidance behaviours were related to issues around authority and/or self-sabotaging. Overall, the relating style was understood as exhibiting behaviours that were anxiety driven (i.e. acting out, needing constant reassurance) and having high emotional variability (i.e. showing ambivalence, approach-avoidance). Moreover, unlike the avoidant styles, this style was perceived as been full and expressive when in contact with others.

"Well, there is obviously issues around the rejection because he is being put up for adoption by his biological parents and while he is a teenager he is arguing a lot with his foster parents. I would imagine that there is a recurrent pathology there, with authority figures. He may perceive support workers as an authority parental figure". (participant 2, focus group 3)

"For this young lad there is so low self-worth, somebody cares and being cared for could be just terrifying and I am just wondering whether this is the feeling that he gets from people, somebody cares about me becomes a frightening thing. Almost

for a period of time he started engaging more and making progress so he is developing a relationship and then that becomes bloody scary so he disappears. […] When I initially read that, it made me really sad. I want to show the client that it can be different". (participant 3, focus group 3)

At times professionals interpreted disengagement as a personal rejection, while in others disengagement was anticipated and perceived as the norm due to the high complexity of service users' needs. When looking at staff assumptions about what lay behind certain patterns of behaviour, it was evident that the majority felt that the very fear of rejection not only interfered with service users' ability to form a trusting relationship and access support but increasingly contributed to poorer mental health outcomes. Professionals perceived those individuals as showing poor interpersonal boundaries, becoming easily emotionally overwhelmed and complying in support that is not necessarily responding to their needs. At the same instance, they suggested that those service users tend to develop high attachment dependence on staff, while maintaining low trust in themselves. They rely on others to make decisions but at the same time appear to be wary of staff and relationship-ambivalent. As a result, a need for an increased tolerance to anxiety, intensified emotions and uncertainty were necessary tools for practitioners to be able to respond appropriately.

"I think when you see real vulnerability in people it does provoke that sense of care and protection and fear as well. It has actually reminded me of someone that I did work with and I was the only professional that he would engage with and I was absolutely destroyed because of the level of self-harm. It was a very child-like behaviour, 'this is my wound I need someone to do something with it, I am screaming here and this is the only way I can communicate it', but it does kind of throw you into a sense of 'oh my god, is he still alive?' every time he disappeared. I haven't worked with anyone quite as full on as that. You can get sucked into that and you can get sucked into the behaviour and the cycles and fear and sometimes with certain individuals, it is like feeding the monster …because to actually suggest to this young man the impact of his behaviour on me was quite abusive he would be terrified. I think that you may end up containing a lot of the emotion". (participant 1, focus groups 1)

"I keep thinking that this is just a child and again about the engaging and non-engagement stuff…I am thinking he would obviously trigger all kind of feelings. If he disappears and then he is engaging, we would think why is he not engaging.

> So there is still some level of engagement. An extreme side. Only on his terms, because he is engaging as he pleases. […] I have seen that with people a lot. They may say that they can't be bothered with any of it and they just want to shut the curtains and hide away from the world for a wee while. It is about reassuring the person that the service is still there". (participant 3, focus group 2)

Service users' alteration of approach and avoidance combined with unpredictability created additional challenge and confusion for staff. Practitioners suggested that a typical behaviour entailed demanding urgent same-day appointments but then not turning up. This type of "*engagement of non-engagement*" (participant 3, focus group 2) created high levels of stress and disturbance to staff, as those service users were deemed to be highly vulnerable and often desperate for support. Some practitioners discussed how this behaviour may make them feel inadequate in their role: *"You can do just as much when they disappear. Your hands are tied. Sometimes I panic because I am aware of how easily they can be exploited. It is terrifying"* (participant 1, focus group 4). The low confidence in self and others placed additional pressure on practitioners who had to prove themselves worthy of trust: *"You have to have the patience of a saint and just show consistency and persistency. Even a small thing could make a difference sometimes"* (participant 4, focus group 3). Understanding the reasoning behind disengagement and a service user's unique processes were viewed as essential in preserving a sense of hope and optimism about their future and recovery.

> "When you offer help you may push the client further or you can bring the client closer. This is quite anxiety provoking for us, finding where exactly you stand. I am sceptical about client's readiness. I mean there is an element of that, but readiness is related to a history of previous experiences of help through family, friends, services etc. So readiness seems to be something that you can build or destroy in the process. As I said, this client is going back to previous stages. This kind of make you feel stuck with the things you can do, so in a way that is how the client feels. We are both stuck". (participant 1, focus group 2)

Although consistency in providing support was a given in most cases, professionals had to be able to decipher service users' responses to increase engagement. Disappointment and frustration resulting from having high expectations were reported as a common experience when working with fearfully attached individuals. Analysis indicated that a significant challenge for the majority of staff was to be able to align their own

personal expectations with a client's own processes. Providing support at any time and as required, even if the client was pulling away when help was given, was said to be exhausting for practitioners. Practitioners felt that having high expectations was related to greater levels of disappointment, especially in cases where service users had engaged for some time and have taken steps to transition off the streets. In this view, being prepared to offer support on an open-ended basis and develop realistic expectations regarding service users' processes when transitioning out of homelessness were paramount for practitioner's well-being.

> "I have a client that fits this perfectly. He has relapsed a lot of times. It is important to be consistent but also accept where he is at the moment. I know for example that he can do better; he can be another person but it is ok to meet him where he is. I accept that. And this is where sometimes we go wrong because sometimes we want to fix people and make them better, it makes us look good professionally too and the service looks better too. The whole thing gets complicated. […] Trying to shape the client around the service a bit more as well, isn't? Instead of clients always fitting into that box, that is where most of our clients won't fit anywhere. And it is about creating a box that suits them". (participant 3, focus group 2)

> "I can feel quite frustrated sometimes, I don't mean I am on a mission… you get to a point and get everything in place and this person is doing really well and you have taken all these steps and then they come to stand still and they either disappear or they do not want to do anything else. I find it really hard because you do put all this work in and you can see how positive it can be and how great the person can do and things are falling down. You just think to yourself, 'if you have done it- that is their life being so much better'. But I do have to think 'who am I doing this for?' I know it is for the person that sometimes you want this good result and you may want it for all the right reasons but sometimes I can get emotional, I can feel quite sad and upset…there is an emotional investment as well". (participant 2, focus group 4)

8.2 Practical techniques and approaches

This sections looks at general and specific methods used by staff members when working with challenging behaviour to optimise engagement and prospects of recovery. In additional to reflecting on the four insecure attachment styles, the focus group discussions highlighted 'typical challenging behaviours' which take place in a homeless service setting.

Types of behaviour that were highlighted and routinely arose in front-line services were: avoidance or dismissal of support, sudden shifts from co-operation to rejection, high dependency and overreliance on services (and/or staff), and high levels of anger/hostility towards staff members or others. Those behaviours, although commonly occurring and fully anticipated by staff, often created a huge challenge for them.

Staff members reported a number of practices and techniques that they found improved their interactions with service users who exhibited challenging behaviours. Persistent encouragement and consistency in their approach were identified by the vast majority. Those elements along with good communication skills, empathy, openness, staff members' expertise, and personal qualities were viewed as essential variables in building a trusting relationship with service users. The ability to convey understanding, be insightful concerning service users' needs and the degree of awareness and experience around mental health and negative coping strategies were considered paramount for developing a shared understanding. Practitioners identified that for constructive engagement to occur, building good rapport was the first step. Their reflections indicated that it was often the quality of the 'alliance' between staff and service users that accounted for positive outcomes. However, the concept of a strong relationship is sometimes at odds with homeless services' commissioned goals, defined as they often are by short-term support plans and traditional 'hard' outcomes.

> "It is really about building trust and taking a couple of days to meet the person, possibly making sure that you are going to them if they are not coming to you. We would go out and try to meet with them somewhere they feel comfortable and then just taking that time to building a relationship, getting to know the person, because this is just crucial. It is the little things that build up because people get overwhelmed about how to do things. You can't just jump straight into it even though it may seem to us, 'oh my goodness we need just to have a housing appointment straight away'. For that to work you need to have like a base and then when you do get to that stage just keeping it going". (participant 3, focus group 4)

> "I used to work with a young man and it literally took me six months to get him to have anything more than a monosyllabic conversation with me. He was one of those guys that you will get so far and it will be a tiny wee thing that would mess it up. You had to be very careful. He was very mistrustful, very high anxiety. But there were reasons for that. I was just getting to understand what those reasons were and allow him to talk about that, really starting to help his situation. It really

makes a difference having the time to work one to one with each client. The more information you may have about the client the more proper support you can offer to the person". (participant 1, focus group 1)

Approaches and techniques were discussed by staff in relation to the presenting behaviour in each case scenario. It was suggested that individualised responses were critical, rather than getting caught up in potentially unproductive protocol-driven interactions. For instance, when an individual was exhibiting hostility towards the staff, the reaction and steps taken where most often based on the service user's unique presentation on the day rather than on set guidelines. Challenging those types of behaviour were reported by a few staff members, but most opted for a less interventionist stance and provided space for service users to approach when ready by walking away when they were in distress: *"It is about learning to disengage"*. Practitioners discussed that initial meetings were particularly useful in ensuring that service users were aware of the type of support offered, the responsibilities and boundaries. However, hostile behaviours and any display of intense negative affect (e.g. demanding, defensive clients) posed a significant obstacle in establishing positive rapport. Taking a broader vision of 'what the main problem was' behind those intense displays was said to be a helpful strategy for practitioners to keep in mind during their day to day interactions.

"Having an honest conversation is a really good start. When I start working with somebody I will always be 'ok, how do you want to do this, do you want me to be really straight with you or want me to kind of…?' they are like 'no just be really upfront'. So then I go back to the client and say, 'do you remember that time you said you wanted me to be upfront with you'. Gets a bit of honesty in quicker sometimes, because you are kind of saying 'I notice that you are feeling really agitated, so do you want to leave this today?' It is not about challenging on behaviour but they just old enough to understand this. 'I am noticing this and I am wondering what does this mean' and they may carry on being angry so I may just go 'I am feeling that maybe this is not the best day I am feeling a bit agitated because you are so…why don't we leave it'. […] It is the empathy saying 'I am here with you, I am noticing and I am feeling this, so actually I am going to step out now' because I think it is alright to be upfront with people because there is nothing worse than not being. People will pick up and I think that people that we are working with are so highly sensitised. It is important because I think people don't have much honesty or safety in their lives". (participant 2, focus group 1)

> "I think for me when I am in a professional mode and you get someone like that (vignette 2) who is really challenging, I am always try to think to myself: 'Look behind the behaviour, look behind the behaviour'. And I think this person has to be him or her all the time 24/7. After an hour I walk away from this person, but this person has to be in that hate constantly. That sometimes helps me when I am getting too caught on the behaviour and I find it really difficult. For me it is a real shock back to being focused. You know I can do this for two hours and if you need someone to rattle for two hours or take things off your chest or whatever support you need, this is fine". (participant 3, focus group 2)

Project workers are not therapists, yet meeting fundamental psychological standards (i.e. understanding trauma and relational behaviour) is essential for all care-practitioners. Practitioners often pointed out elements in their relationships with service users that were similar to the therapeutic alliance formed between a therapist and a client. For instance, ensuring the client's needs are put first and foremost, and the established relationship is characterised by safety, consistency, reliability and appropriate boundaries. Those elements were mentioned as necessary components in order to occasionally foresee certain reactions and more importantly to maximise the chances of positive outcomes. Although the focus of the relationship differed altogether (when compared with a therapeutic relationship), the skills and expertise of practitioners, honesty and openness to explore what is going on for the service user were similarly often the answer to a good rapport over time.

Practitioners' reactions and attitudes towards service users were critical to the formation of a strong alliance between the two parties. The dynamic process between service users and practitioners involved a 'here and now' interaction that could strengthen engagement and facilitate constructive changes in behavioural patterns. This entailed not only being aware of one's own experiences but also being emotionally available and open to discuss a problem with the service user. Staff members had to bring elements of themselves into the relationship with their clients (e.g. authenticity, own experiences, values and views). This at times entailed also expressing feelings of anxiety and frustration. Practitioners discussed that in many cases, expressing their genuine feelings was helpful in enhancing engagement and achieving better outcomes. However, processing those feelings either with the assistance of their colleagues or potentially with an on-site psychologist prior to expressing them was necessary in avoiding unproductive encounters.

> "It can be really powerful for the person when there is real honesty. They gradually realise that when I do this, ok… it can be scary for others. Instead of closing your

stance, you remain open but it is not going to be an argument. It is going to be more like 'please don't do this'. And they don't realise this until you said it sometimes". (participant 4, focus group 2)

"I think that I had separate conversations when I have been very open and very honest about how it made me feel about something that has happened. Something that is quite significant like a serious incident. I think it is absolutely key to have these conversations because they need to know that we are on their level and we can have those discussions. If there is no honesty there is no relationship. It just makes the relationship stronger. It is ok to not get everything right all the time too". (participant 3, focus group 4)

The majority of practitioners used intuitive approaches to problem solving in their daily practice. Some suggested that using humour and reducing focus on emotionally charged material could help to resolve difficult encounters. In other cases, monitoring service users' mood and anxiety levels as they come into the service can facilitate a successful intervention. In all, the transformational nature of relationships was seen as a key tool for meaningful change. However, when staff and service users were constrained by conditions such as rigidly set appointment times, the effectiveness of any intervention was compromised. Building a relationship of trust and respect was seen as a collaborative process that necessitated commitment, creativity and open-ended attitudes, rather than set restrictions (i.e. time restrictions, curfews etc.) in the way that services and staff members could work.

"For me it is liberating that there haven't been expectations of attending appointments. If they don't attend three appointments, then they are struck off in most services. While in this service I have the freedom and the client has the freedom that if they don't engage and it takes a few attempts for somebody to meet with me, that is ok. I think it is really liberating for the person and for me, because the pressure for the workers is off as well. I think you just give better support if you are not going - Come on we need to get this done". (participant 3, focus group 2)

"When working with people who have experienced crossing of boundaries, or have not had any boundaries and still kind of not been able to relate to people the way we are able to relate to people, the social skills just aren't there. So it is not about punishing people for that, it is about taking the time to build that relationship and

educate them. I think it is just being human, just treat people with respect but also being clear about the boundaries. We have a certain tolerance to behaviour, we are not punching bags, so let's just stop and find another way of doing this. It doesn't happen right away but it eventually does". (participant 5, focus group 1)

However, not all practitioner participants felt confident in their role. Occasionally, staff members reported being caught up in service users' behaviours and reactions. For them, working with service users' conflict and emotional turmoil produced considerable anxiety and stress. They noted that at times, they fell back into defensive processes and resistance. Existing research indicates that counterproductive reactions such as anxiety and covert hostility are likely to be evoked under those circumstances (Adshead, 2001). For instance, when working with highly angry-dismissive individuals, confrontational approaches or more rigid interventions can arise. As one practitioner explained: "*Sometimes all you want to do is shout back and leave the room"*. Alternatively, when working with anxiously attached individuals, practitioners may result in intervening more intensively, or allowing greater dependencies: "*I could feel with this client going on mother's mode too often […] I thought that maybe another worker can help*".

Analysis suggested that when being highly sensitive or insensitive to a service user's cues, it was particularly difficult to tolerate and attend effectively to the client's needs without being defensive or personalising the situation. In those instances, seeking the advice and support of colleagues, attending adequate training and taking part in reflective practices, often allowed practitioners to deal with both their own and the client's emotional crises*: "Sometimes you need to ask yourself the question, 'how does this client make me feel?' It will give you a clue what the client is trying to communicate to you and how he feels".* (participant 3, focus group 2)

"Personally I would like to make this clear, more often than not I have the feeling that we expect the clients to make us look good professionally. Competent enough to justify our payments, to feel good, to go home and say: 'Yeah I helped someone today. I have a purpose through life.' But most often you end up feeling frustrated, very incompetent, limited…I don't know all sorts of ways. The typical feeling happened to me this week, client saying 'I need your help, give me a call, it is urgent'. You call them and they are either not there or they may say 'I really need to meet with you', so you book an appointment and they are not coming. It makes you think, 'I am not communicating well' but usually it is not about you, it is probably about them". (participant 1, focus group 2).

> "There are certain individuals which they will continue to push if they see a bit of soft edge in you. They need to know you too but you need to know yourself first and know where your boundaries are because you can see people play staff…test them. But staff needs to push back and test back a wee bit and that is something difficult. This is where you see the difference with new staff members. That is where you need the confidence to say; I am actually quite intimidated but I am not going to do this. Part of you has to just stand up". (participant 4, focus group 1)

Overall, practitioners reported relying on their existing relationship with 'challenging' service users rather than using any coercive strategies or confrontational approaches. Relational factors, such as adapting to the unique needs of each service user and working through conflicts were deemed essential for good outcomes. For fostering hope and being responsive to service users' needs, practitioners highlighted the value of helping them to feel understood and listened to. In many cases, collaborating on tasks and setting goals necessitated openness and flexibility, as well as spontaneity and authenticity. In extreme cases, light-touch contact on a service user's terms had assisted in eventually developing a base of trust: *"The consistency should be offered without overwhelming the client"*. Consistency, patience, flexibility and stick-ability were the key elements mentioned when supporting any client with complex needs.

> "It is all about just trying to kind of chip away those barriers by keep offering support every time I see them. Being consistent and let the person know that they can trust us. Sometimes they can be like an oyster. I kind of found through the years that is like when you are kind of meet people that don't engage with you, it is just about making the effort of kind of passing by and saying hello and through that time one day you are walking by and they are kind of shouting you over. They have seen you passing by so many times, maybe they have watched how you interact with other people and what you do, or they may have asked other people about what you do and who you work for and whether they can trust you. And then they kind of shout you over and you start building up a relationship". (participant 2, focus group 3)

8.3 Working with challenging MEH populations

8.3.1 Impact on frontline staff

The relationship formed between staff members and service users itself is a vehicle for change and this section further highlights the significance of professionals' personal traits in creating the conditions for sustained engagement. Professionals pointed to their critical role in building trust and mobilizing service users' strength and resources. However, maintaining an attitude of hope and optimism was a particularly difficult process which challenged practitioners in their daily practice. Working with complex clients and continually dealing with trauma and addictions can result in high levels of burnout and vicarious traumatization to the extent that it can impair staff members' job performance and sense of self-efficacy. Minimal education and training for working with complex populations, as well as the lack of supportive networks and reflective practices in many services were viewed as exacerbating factors which appeared to have serious implications in increasing work-related stressors.

Focus group participants reflected on their role in affecting change, whether this is psychologically, physically or socially in their service users' lives. Working with people with multiple support needs and experience of high levels of trauma was said to necessitate parallel work with oneself. Setting professional boundaries, dealing with stressful events and difficult emotions or simply working with service users who are difficult to relate to can be emotionally draining and lead to feelings of hopelessness and disappointment. Staff members acknowledged that it is easy to get irritable or defensive, or even engage in counterproductive interactions in this line of work. Awareness around trauma and related behaviour seemed to partly mitigate such difficulties.

> "You can't be professional all the time, you have to bring yourself to this and show your own vulnerability and show your own self. If not they may as well be talking to x, y on the phone. They invest in you and you need to be genuine, you need to be yourself or they can just see right through you. You think you are assessing them but they are really assessing you". (participant 4, focus group 2)

> "I think that we often forget that if the clients want to have a relationship with a service, they have to have a relationship with themselves. And usually the relationship with themselves is not a good one. They hate themselves, they are ashamed of themselves, they are angry with themselves. So they are making a relationship with the service, through you. So you are exposed to all this,

constantly. We are trying to make ourselves useful at all levels I would assume". (participant 1, focus group 2)

Participants agreed that this line of work *"is not the typical 9 to 5 job"*. The impact of trauma, such as burnout experiences and staff demoralization, were common phenomena within front-line homeless services: *"It is a constant, constant draining and negativity, negativity, negativity. It comes Friday and you are exhausted"*. The daily exposure to high levels of mental health issues, addictions and trauma (including histories of child abuse, domestic violence and violent crime) becomes a source of trauma in itself for staff members.

The degree of perceived difficulty, sensitivity and responsiveness to distress differed from one practitioner to another. The length of the professional experience and the personal characteristics of staff appeared to influence, in part, these variations in response. That is to say that although all staff are exposed to severe levels of trauma, more experienced practitioners in this line of work may have normalized certain behaviours and become desensitised to the challenges and horror of people's circumstances. However, previous research suggested that constant exposure to trauma could reduce practitioners' empathy for their clients, while any personal experiences of trauma could be heightened through this process (Howell, 2012).

"I am just thinking about […] the effects that hearing about the trauma than can get in you. I think we totally underestimate the effect it has on us. I think there are times where you are having good days, you can hear this and you can keep it there and I think a few not great days then that can get you. There are also things happening in your personal life, I think that is when you start to feel quite physically and emotionally weary, it is not even connected to that person but it is just the effect. We may speak about it at reflective practice but a lot of the time when we are doing reflective practice, the main thing is always let's focus on how do we support this, how do we support the client better, how to get unstuck with something, how do we deal with this and sometimes at the end of that conversation it will come up 'What is that like for you?'. Sometimes I feel we should be having more reflective practice just on how it is for us. I know we have supervision and stuff but sometimes I think it would be a good place to have this group just about how we are managing the trauma that we are hearing". (participant 2, focus group 1)

"We are dealing with trauma every day. We deal with traumatic situations and the outcomes are not always good and that can be on daily basis. The amount of people that they have passed away as well, that can be quite traumatic in our job. […] It is that you come across people's misery. Sadly, we don't tend to have a lot of happy stories in this line of work and when you do it's great!" (participant 2, focus group 3)

"I had someone so destructively worrying that I was experiencing a barrage of no hope in every meeting, I was gradually feeling dirty myself and in despair. I was always going to see him early in the morning to take this out of the way. I think it is a matter of control, because the problem with these guys is the uncertainty. I want to be professional and I want to be good. But when you don't know what you will get, it's exhausting. - Am I getting the good side today or the abusive one?". (participant 1, focus group 2)

Maintaining the right frame of mind necessitated feeling supported within the work environment. Its significance was reflected in both facilitating long and stable relationships with service users and in improving staff members' morale. On many occasions, service users' progress was hard to perceive. Although practitioners did not attribute the outcome of an intervention to themselves, they clearly vested themselves in the service user's choice to engage or not with a particular service. In those cases, supervision and reflective practices were integral to the outcome of the work. Reflecting on the work with the support of others assisted practitioners in managing their feelings and maximizing their potential to assist their clients. It also signified the value of relationship work in tailoring positive engagements with hard to reach populations.

"You get a big chunk of the client group who think that we are support robots and we don't have any feelings and they can offload everything to us and it is fine. 'This is his job he is getting paid for', this sort of thing. But we are still emotionally processing things as well and we also have our own stuff in our lives that sometimes can get in the way". (participant 3, focus group 2)

"You become like a role model to them. I think they look at how you manage any setback. Do you get angry? Do you get frustrated? Sometimes I would say to my colleagues that it is ok to get angry and frustrated but as long as you are not putting this onto them, just go and speak to other staff and go to reflective practice. I think

it is really important to have a reflective time and look at what is happening. It is about supporting the worker as well". (participant 5, focus group 1)

"I think it's really tiring fighting with your mood. I think the most tiring thing is keeping your mood to a level. Because sometimes people may be affected by others things, such as their own ways of doing things. Changing your mood and attitude to go with the mood of the people you support can be quite difficult". (participant 4, focus group 2)

8.3.2 Using attachment to inform practice

In aspiring to provide personalised and client-centred services, a central aspect of the PIE approach calls for practitioners to have an in-depth understanding of service users' relational behaviour, trauma and struggle to trust. Recognising the impact of attachment disruptions on service users' life is a fundamental part of establishing effective engagement. For instance, *"factoring attachment into the appointment system is one obvious step that would help to create genuine personalisation in practice by ensuring a standard of continuity…"* (Seager, 2014, p. 220). There are a number of general and specific methods that can be used when working with highly insecure individual to optimise care. However, a basic understanding of the 'secure base' (Bowlby, 1988) and how disrupted attachment shape behaviour in homeless populations is a prerequisite (Woodcock et al., 2014).

As previously discussed, practitioners named a number of practices that they found to be helpful in their day to day practice. Practitioners agreed that all insecure service users may benefit from interventions aimed at improving their capacity to relate, such as clarifying expectations and considering their view, finding out about their social support network, understanding their coping strategies (be they effective or ineffective), and discussing any problems with the service user. Nonetheless, targeted interventions towards specific defensive processes and needs are also necessary. For instance, service users with enmeshed styles tend to have high attachment dependence anxiety. In those cases, discouraging a service user's tendency to amplify symptoms for accessing help by providing brief regular appointments regardless of symptoms can be helpful. In addition, providing support but avoiding constant reassurance can bring positive outcomes in the long-term. Alternatively, for those that tend to have both high attachment dependency/anxiety and high attachment avoidance (dual/disorganised style), being very consistent and providing a sense that things are under control, and/or setting limits when necessary, were mentioned (by staff members) to be particularly helpful tactics.

However, the collaborative process of any relationship implies that it is not solely the attachment styles of service users which matter, but also those of practitioners. In clinical settings staff members' differences in attachment styles have been shown to affect the level of care provided, the sensitivity of the topics raised, how boundaries are set, and how practitioners may respond to relationship rupture (Bucci et al., 2016; Wilhelm et al., 2016). Existing literature indicates that the more securely attached practitioners are, the less likely they are to interact in ways that may be counterproductive (Dozier et al., 1994). In other words, staff members' attachment styles and own levels of anxiety affect their perceptions and reactions towards clients (Berry & Drake, 2010).

For instance, practitioners with an avoidant style are more likely to perceive highly insecure service users as 'difficult' to work with, while anxiously attached staff may be more prone to be compulsive caregivers in their daily practice. Furthermore, staff members' attachment styles have been related to difficulties in empathising with others (Joireman, 2001). That is to say that more avoidant or anxious staff may be less 'available' or insightful concerning service users' needs (Britton & Fuendeling, 2005; Berry & Drake, 2010). Overall, psychological and counselling research suggests that in forming strong alliances with clients, being mindful of attachment theory is crucial. When difficult circumstances arise, attachment styles can be used to 'predict' and plan for possible problems. Individualised responses are necessary and it has been suggested that matching the styles between practitioners and clients (although not easily applicable) is the ideal approach for fostering more constructive interactions (Bruck et al., 2006; Bucci et al., 2016).

8.3.3 Strengths and limitations in action

Front-line staff perceived the relationships with their service users as the 'vehicle' for fostering positive change. Task-oriented approaches were seen as the ultimate goal, but establishing a trustful relationship was viewed as providing the conduit for addressing any practical needs. In some cases, it could be said the relationship was resembling a form of pre-therapy, where for instance word for word reflections facilitate some initial contact and no major demands are made upon the clients. Practitioners' skilfulness, positive relational manner, professional experience, a sense of 'curiosity' about service users' motives and behavioural patterns and interest in creating a safe environment for all also reflected positive interactions, high confidence and enjoyment in day to day work. Staff members discussed how a difficult week can turn into a positive one when overcoming difficulties and when service users eventually make a positive change in their life and recovery, or just

start to engage in meaningful ways. Their role in fostering independence, supporting and tackling the problems even of the most entrenched rough sleepers was perceived as highly rewarding and produced feelings of personal accomplishment and satisfaction: *"There is always a way out, you know and when they kind of start seeing that too… you feel as if you have saved a life"*. (participant 3, focus group 3)

In practical terms, maintaining a positive approach and establishing strong attachments can be difficult considering the high levels of relapse, disengagement and negative affect amongst people experiencing MEH. Furthermore, often the lack of adequate support to prepare for these stressors and alleviate emotional exhaustion can increase the levels of burnout amongst staff. Focus group participants' identified a number of training needs for effectively addressing these challenges and providing effective support for their clients. Among others the limited co-operation between services was highlighted. It was suggested that the efficiency of interventions is linked to effective communication among services, however multi-agency approaches are still in their infancy. Meanwhile, the lack of adequate mental health services for individuals who face multi-faceted, complex and chronic issues places greater demands on practitioners to engage in therapeutic work without necessarily having the requisite skills and training. Although understanding and managing problems arising in the social interactions between practitioners and staff members are at the forefront of any support work, participants often discussed feeling 'out of their depth' especially where service users were affected by enduring mental health issues.

> "I think the problem is we don't have enough mental health support. Although we are used to dealing with mental health issues and you are referring them on, it almost tends to be the emergency case, when they have actually violently hurt themselves or violently hurt another person before they get picked up by a mental health service. I feel I had to phone the police and say I am disturbed about this person's mental health and it has to be them who intervene rather than me phoning the emergency department and say 'Well I don't think they are a risk to themselves' so it is hard to go that extreme. I don't think you should have to do that. This is really difficult, we kind of know there is something there but we are not mental health specialists so sometimes we don't know how to support somebody because we don't know what their mental health is either. You just have to try and support the relationship properly and try to stabilise something but we are not really sure what that might be". (participant 3, focus group 1)

> "What I have noticed more is that more and more services are working together, including like a CPN going to the night shelters. I think even all the different places working together has made a difference towards better support. This is a new thing and it is happening more and more and I think it is a good thing that people are working together now, not so much in competition as they were maybe a few years back. It's a start. It has always been about the differences in what each organization does and trying to hide how you work with your client. I think we're just starting to realize that we all got the same idea of why we are here and why we need to work together". (participant 5, focus group 2)

Overall, practitioners had varying levels of tolerance toward challenging behaviours and had their own interpretation of service users' attachment avoidance and dependence. These differences were reflected in their capacity to connect with service users and which groups of service users were perceived as more difficult to work with. The majority of practitioners appeared capable of identifying and containing service users' difficult experiences to a certain extent. However, increased professional stress levels were negatively affecting both the relationship with clients but also staff's self-efficacy and mental health. Professionals were constantly striving for improvement and attending to both clients' and their own needs. However, their own processes were often neglected and undervalued within the work environment. Considering their own contributions in the day to day interactions, and seeking support and advice when challenging interactions arise, were seen as useful tools for understanding and dealing with daily challenges. It was suggested that not being overburdened and having regular and skilled supervision were absolutely necessary. In this vein, using attachment-based approaches to staff and service users' interactions might significantly assist in understanding behavioural styles and minimising potential defensive strategies and counterproductive encounters.

> "I think this (focus group discussion) is a great therapeutic and reflective exercise because it is a useful tool to reflect on how I may feel about certain clients. I haven't given much thought to it. I know that certain clients may make me feel particularly bad about something but I didn't think much about the reasons behind their actions or why I may feel like this". (participant 1, focus group 2)

Conclusion

This chapter focused on exploring whether service users' different attachment styles do induce different cognitive and emotional responses in staff and whether staff reactions

to these have a substantial influence on the nature of the service user-staff relationship/interaction. Service users with anxious patterns of relating appeared to often evoke feelings of compassion in staff, while their openness to collaborate with services (at least at first stages) and accept help was leading to more open staff/service users' interactions. However, their high ambivalence and at times overdependence, the 'push-pull' in relationships and constant need for reassurance were placing staff members at a high risk for work-related stress and exhaustion. On the other hand, avoidant service users appeared to be more likely to 'fall through the net' and ran the risk of being dismissed, as they were often avoiding expressing their needs, seek support and eventually engage with a service. Their high need for self-reliance, and at times hostile and dismissing attitude evoked feelings of frustration to staff who reported experiences of burn out and job dissatisfaction.

Evidently, difficult service user-staff member interactions are common in front-line homeless services and they often constitute a barrier for providing effective care. Such interactions tend to have negative emotional consequences for both parties, calling for a shift of our focus away from the idea of the 'difficult client' or the 'difficult interaction' and pay more attention to the social aspects of the relationship. We tend to think that the main endeavour of staff members in homeless services as being to assist service users to transition off the streets and contribute to improved outcomes for employment, confidence and life skills. However, the analysis revealed that there are a number of 'invisible' aspects in staff's responsibilities. This type of work relies heavily on the capacity to build positive relationships and create the right conditions in which this capacity is actualised. In this respect, staff members are implicitly asked to model a functional relationship and respond with enough consistency and continuity to build a base of trust for their service users.

Analysis also revealed that to a certain extent staff members' approaches were tailored to suit service users' style. In this respect, the significance of staff members' personal traits in achieving the necessary outcomes was stressed in all group discussions. However, this 'demand' often exceeded their resources to cope with the daily work pressures. Consequently, at times professionals were caught up in unproductive interactions and/or felt emotional drained and stressed out. Developing attachment based interventions (general and specific) in which the underlying traumatic experiences, coping strategies and attachment styles are given careful consideration, can increasingly improve day to day interactions. This entails recognising the centrality of relationships as a tool for change. In this light, staff will require to have an understanding of attachment styles and how those may condition service users' reactions. This may reflect on the chosen

intervention but also in matching the chosen intervention to the characteristics of the service user.

It is crucial though to keep in mind that such interventions necessitate engaging in reflective practices, attending appropriate training and having on-going support within the work environment. These are considered as necessary resources to cope with the impacts of exposure to daily trauma and are key aspects of any psychologically informed intervention. The work that staff members are asked to do when supporting insecurely attached and emotionally damaged service users is primarily psychological. Emotional challenges may underpin most interactions, thus it is crucial to understand the limitations of current approaches to homelessness and rough sleeping and endeavour to develop a framework that is psychologically safe for both services users and staff members.

Chapter 9: Conclusion

This study aimed to identify the attachment styles of individuals with experiences of MEH and explore the relevance of their attachment experience to the behavioural and relational patterns that emerge when they engage with support services. This chapter draws together the study's key conclusions, before then reviewing its main contributions to scholarship, strengths and limitations, implications for practice, and direction for future research.

9.1 Key conclusions

In addressing the first research questions which focussed on the prevalence of different attachment styles amongst people with experience of MEH, it was found that all participants exhibited insecure attachments and their support context and quality of close relationships were poor. More than half of sample displayed a more complex attachment style, the dual/disorganised style. Of the 30 total participants in the sample 20 displayed a primarily anxious attachment style and 10 were assessed as having a primarily avoidant style of relating. Overall, 22 participants were assessed as having dual attachment patterns. In terms of degree of insecurity, the vast majority (24 out of 30 participants) were rated as markedly insecure and only six participants were rated as moderately insecure. For the majority, their close relationships were assessed as being insufficient and inadequate on quality and support.

When considering the role of attachments styles in the causation of MEH - the focus of the second research question - it was found that attachment trauma and styles formed a key causal mechanism by 'driving' individuals to lose their sense of self and engage in aberrant forms of coping. Analysis revealed that participants were in some ways 'entrapped' emotionally, psychologically and socially before and during experiencing homelessness. Early adversity within a care-giving relationship was commonly reported and often increased vulnerability and sensitivity to stressors, and interplayed in the formation of insecure attachment styles. In parallel, the attachment style formed influenced the relating capacities of the individuals and their coping mechanisms. Depending on context and the personal characteristics, those coping skills and relating styles can potentially lead to aberrant forms of coping, difficulties in forming supportive relationships and the development of mental health difficulties. As they inherently limit one's capacity for resilience and healthy functioning, they also hold the capacity to launch someone on a pathway into homelessness.

The psychosocial mechanisms (i.e. attachment concepts, impact of trauma etc.) that underpinned causation and could explain the way things act and how they are capable of doing so were often neglected in literature. It was thus necessary to engage in a reflexive account of the underlying and potentially 'hidden' mechanisms and relationships between constructs beyond the initial thematic analysis. This process initially entailed the identification of patterns and themes within the data and consecutively the reconstruction of those themes with reference to the specific setting. In turn, attachment theory offered the framework to think about the layered meanings of individual themes and the mediating relations within and between constructs.

Examination of the influence of attachments styles on the relationships between service users with experience of MEH and support staff was prompted by the third research question, and revealed that attachment styles determine the behavioural strategies when seeking support from others and forming supportive relationships. The actual engagement in proximity and support seeking were driven by the individual-based strategies associated with attachment avoidance and attachment anxiety. In brief, highly anxious individuals exhibited intensified demands for care, overdependence, controlling and clinging behaviours in order to elicit care. In contrast, those with an avoidant style of relating disengaged easily from relationships and support and exhibited high self-reliance. Identifying participants' attachment styles and degree of insecurity assisted in developing a better understanding of their behavioural tendencies, predict potential problems in the day to day interaction and shift attention away from an unproductive focus on the 'difficult' service user.

Finally, the fourth research question's focus was on staff members' cognitive and emotional responses to service users with insecure attachments. The study identified a range of reactions and responses depending on the attachment style of the service user. Individuals whose attachment styles were characterised by high anxiety appeared to have higher expectations and demands and be more able to verbalise their needs. Staff members commented that they had a tendency to be more emotionally attuned when service users appeared to be 'loud' and vocalize their needs. However, those constant demands and displays of negative affect were identified as being quite emotionally draining and occasionally intimidating for staff members. In contrast, individuals scoring high on attachment avoidance appeared to be self-reliant, maintain their distances and downplay their need for help. In some cases their engagement styles were characterised by active hostility to staff and service provided. This led to poor communication, great difficulties in engaging and maintaining relationships and increased levels of exhaustion and burnout

amongst professionals. Overall, staff members reported that those service users were more likely to 'fall through the net' of support.

9.2 Contribution to scholarship

The study has contributed to scholarship in a number of ways. First, it has enhanced understanding of the role of attachments in the lives and service use of one of society's most excluded and disadvantaged populations. To date there have been only a handful of studies exploring the attachment styles of homeless individuals, and the link between specific insecure attachment styles and engagement with support has not been explored at all. Previous studies identified insecure styles of attachment within homeless populations with avoidant and disorganised styles being the most commonly reported. This research added to the current literature by also identifying high levels of insecure attachment amongst MEH individuals, with more than half of the sample displaying a dual/disorganised style of relating. Research suggests that this classification most often reflects some earlier unresolved loss or trauma (Bifulco et al., 2002; Cicchetti et al., 2006; Riggs et al., 2007b) – a finding that is further validated by the high amounts of early trauma found within the sample.

Furthermore, the applied methodology allowed for more nuanced identification of the extent to which the insecure styles are 'dysfunctional' by allowing for assessment of whether an individual is *markedly*, *moderately* or *mildly* insecure. The vast majority of the sample were rated as markedly insecure. This is important given the evidence that mildly insecure styles carry less risk of mental health problems, as opposed to markedly insecure styles that are associated with high level of psychiatric risk (Bifulco et al., 2004, 2008). Markedly insecure styles are also indicators of poor supportive relationships. Within the sample, only six participants (out of 30) were able to identify a relationship that was deemed as supportive enough. The majority of participants either could not identify any close relationship(s) or reported on relationships that were insufficient and inadequate on support and were often lacking closeness and any positive interaction.

Application of psychological constructs to homelessness with an emphasis on attachment dynamics has been limited in literature to date. This project has offered a more encompassing look at the attachment processes of MEH populations and further added to knowledge of clinical applications of attachment constructs with those populations. Additionally, it drew more attention to the appropriateness of research methods used for assessing attachment styles with MEH populations. Research with socially excluded populations requires sensitivity to enable efficient evaluation of behaviour, support

networks and coping strategies and to inform appropriate planning and effective approaches to care. However, as noted, the identification of reliable measures for use that take into consideration the high risks, vulnerabilities and context specific factors of people with experience of MEH can be a challenging process. Existing literature indicates that attachment measures have not been designed with the heightened vulnerabilities and unique characteristics of extreme forms of social exclusion in mind. There may be conceptual and measurement advantages of considering the impact of social exclusion in the further development of attachment assessment tools.

The study also made positive inroads towards improving understanding of the influence of attachments styles on levels of service engagement and presenting behaviour amongst individuals with experience of MEH. Although in a number of existing studies the role of attachment in relation to a person's ability to access and engage in treatment has been discussed, no studies were identified that explicitly looked into its role in utilising support within a homeless service. Nonetheless, the results of the qualitative analysis were consistent with previous findings in clinical interactions, in that attachment anxiety and avoidance were reflected in service users' interpersonal behaviour and help seeking-processes. In line with existing literature, individuals with higher avoidant attachment were less inclined to seek help from others, were highly wary of others, exhibited poor levels of engagement and poor rapport with professionals. Service users with preoccupied styles presented as 'needy' and exhibited higher dependency to services, low self-reliance and high emotional reactivity when they felt their needs were not being met adequately. A mixture of anxious and dismissive styles characterised those with a dual/disorganised relating style. This style was typified by ambivalence and approach-avoidance behaviours, poor interpersonal boundaries and sudden shifts from co-operation to rejection. It was further noted that those individuals were easily overwhelmed and overwhelming. In other words, their emotional 'chaos' could translate into 'chaotic' encounters with professionals.

Difficult encounters, premature disengagement from services and challenging behaviours appeared to be common experiences reported by front-line staff members. However, an attachment perspective offers a new set of lenses for understanding barriers to engagement and disengagement from care. MEH populations are widely reported to be amongst the hardest to reach and retain in services. The co-occurrence of mental health difficulties with illicit substance use and services' restrictions appear to often account for disengagement levels. Beyond those commonly reported causes, this project further argues that engagement can be also translated as an expression of attachment. In this vein, when

service users continue to engage in relationships with service providers they are gradually forming an attachment with staff members or the service itself.

Further to this, through the lenses of an attachment-based framework, disengagement might also be interpreted as a (different) form of engagement. In other words, the type of relationship formed reflects both the person's sense of attachment security and the ways in which he/she reacts and approach threats and distress. Service users' inattentive, withdrawn and avoidant stance is seen as a response in the presence of stress and an effort to escape from a painful and uncomfortable situation. Individuals with withdrawn and dual/disorganised styles are characterised by having a low threshold for attachment distress and a high distrust of others, while they do not tend to competently seek proximity in times of need. The difficulty lies in service providers 'remaining interested' in the relationship with those service users. An attachment framework offers the opportunity to view disengagement as a pattern of response (a passive response strategy) and while such responses will seriously impede attempts to connect and remain connected with those service users, having an attentive and sensitive attitude towards disengagement and offering consistent and reliable support over time appear to be related to a wide variety of positive outcomes.

Additionally, the study has provided rich empirical evidence that contributes to a burgeoning evidence base indicating that histories of childhood and later trauma, severe mental health problems and addictions, experiences of institutionalization and social exclusion further compromise personal and social functioning. Participants reported how those experiences manifested and reflected in their relationships with themselves and others. Individuals with high attachment anxiety and severe early traumas appeared more likely to report negative post-trauma cognitions and high distrust towards others, experience feelings of isolation and hopelessness and display a diminished sense of self-worth. Individuals scoring high on attachment avoidance were more likely to respond with anger when in distress, push others away and isolate themselves. At times when both high attachment dependence and avoidance were present (in dual/disorganised), inconsistent attendance or ambivalence in decision-making were displayed. Individuals with those patterns of relating were highly likely to display intense negative affects (such as high defences and demands) and become angry and overly distressed when in crisis.

The project also attempted to explore the contribution of attachment experience in the causation of homelessness. Negative attachment experiences and markedly insecure attachment patterns were perceived as critical mediators between early adversity, substance misuse, homelessness and other experiences of social exclusion. Previous research

indicated the significance of relationships and in particular the lack of supportive networks, and early trauma in developing a pathway into homelessness. This project further highlighted the role of traumatic experiences and relationship breakdown in shaping coping strategies and behavioural patterns. Participants explained how being severely traumatised and lacking adequate social support resulted in being more liable to use avoidant coping styles (i.e. drug misuse, isolating oneself etc.) and develop mental health difficulties. The role of insecure attachment styles in heightening hyperactivating or deactivating strategies were evident across the sample. Those internal, secondary strategies stemming from past trauma within relationships often resulted in overdependence and excessively reassurance seeking or in distancing behaviours and avoidance of support. Those elements were considered to be contributing factors in being emotionally and psychologically 'trapped' and thus being more vulnerable to experiences of social exclusion.

In other words, attachment theory provided a framework that could help to explain why it is that some people may be at greater risk of becoming homeless. The causal powers attributed to ACEs, insecure attachment patterns and environmental stressors appear to limit one's capacity for healthy functioning. Although no strong causal inferences could be made in regards to the actual triggers of homelessness, the project contributed to our current knowledge by identifying a mechanism that could explain the link between early forms of relational trauma, coping strategies and homelessness. It demonstrates that highly insecure and dual/disorganised patterns of attachment impact on help-seeking processes, general behavioural tendencies and cognitions (i.e. internalised sense of self-worth, perceived unresponsiveness of others etc.). Insecure patterns could account for poor engagement to services, whilst avoidant and dual/disorganised styles of relating appear to further contribute in prolonging rough sleeping.

Finally, the study has begun to address a critical gap in knowledge regarding staff members' cognitive and emotional responses towards service users with insecure attachments, and offers substantial insight into the influence these have on their relationships and interactions with service users. Using an innovative vignette-based method, the study revealed that staff members deemed responding to individuals with avoidant relating styles as a challenging and demanding task. It necessitated good awareness of behavioural tendencies and consistency in responses. The fact that those service users appear to be self-sufficient and ask for very little, entailed the danger of them being 'dismissed' within services. Furthermore, when avoidance was combined with hostility, then disengagement and exclusion from services was commonly reported. Responses to individuals with anxious relating styles differed profoundly. Staff members

reported that they were more likely to empathise and attend to the emotional needs of those individuals and support them more intensively. However, they also noted that working with highly enmeshed and fearful individuals necessitated an increased tolerance to anxiety, intensified emotions and uncertainty. Significant challenges were also noted for staff when both avoidant and anxious traits were present. Practitioners discussed feeling at times out of their depth when dealing with such cases, experiencing feelings of emotional exhaustion and disappointment, while burn-out and staff demoralization were also commonly reported.

9.3 Strengths and limitations

One of the greatest strengths of this study is that the use of concepts from attachment theory and research has helped shift the emphasis in diagnosis and treatment from a medical model to a non-pathologizing framework. The medical model emphasizes individual diagnostic categories and pathology whereas attachment theory allows for a more relational, ecological framework which considers the influence of personal relationships, society and the wider environment. Insecurity of attachment is not itself a pathology; rather it represents a vulnerability in terms of effective stress and distress management (Adshead & Guthrie, 2015). Challenging and chaotic responses are to be expected, even if they appear to 'work against' one's actual needs. The study of attachment amongst those populations highlights the importance of attending to those vulnerabilities and the contextual influences of relational trauma on behaviour, and look into how those influences might impact on the relationship with professionals and support services.

Furthermore, the majority of research to date appears to study homelessness and causation focusing on economic marginality and personal limitations and characteristics. At the moment, there seems to be a paucity of research on exploring individual factors without conflating them with personal agency and on integrating personal perspectives in explanations of causation. In this light, the study offered a new perspective by emphasizing the role of interpersonal factors (i.e. the relationship with care, staff members and services) and social contextual factors (i.e. social support) which have often only been examined as individual traits. Unlike *intra*personal factors, *inter*personal ones are not so much about the individual but about the individual in relation to others. This appears to fit into a conceptualization of both structural and individual factors, while they are considered to be key in transitioning out of homelessness. When previous research has looked into causes and consequences of homelessness at the level of the individuals, it appears that a tendency toward psycho-pathologization has dominated (Christian, 2003). Furthermore, it has often

failed to take into account interpersonal and relational aspects of social support in its theorization. Public services are relational at their most fundamental level, however they are often designed in ways which neglect the interpersonal capacities and constraints of the very service users that they target. In this light, interventions are not necessarily providing an increased sense of control, or empowering clients to reclaim their lives by honouring their experiences (see Schmidt et al., 2015). I would thus concur with Christian (2003, p. 87) that: *"...examining processes underlying individual's perceptions, motivations and actions is central to opening up a range of possibilities for intervention"*. Interventions should therefore be primarily relational, person-centred and psychosocially sensitive.

In relation to methodological implications, current research methods do not systematically explore issues associated with complex human behaviours and social relationships when studying homelessness. To date there are only very limited studies that examined the attachment styles of homeless populations and even less that used an interview measure. This study filled in those gaps by using the ASI for the first time for assessing attachment styles within a sample of homeless individuals. The use of such a measure assisted in overcoming some of the limitations of more widely used tools to assess attachment styles, such as questionnaires and the AAI. Its contribution to the study was pivotal in a number of ways, including its flexible and sensitive nature, its adjustability to the reporting style of the interviewees and its good applicability to different groups, amongst others. The interview has been successfully used in different age groups, cultures and high-risk community groups with robust results in terms of increased vulnerability of those with highly insecure styles to mental health difficulties (Bifulco et al., 2002,2006; Sheinbaum et al., 2015b).

Further to this, the ASI is the only interview measure that assesses current global attachment in adults, as opposed to historical attachment and a parent-child attachment (such as AAI) or a romantic one (such as most questionnaires). This is particularly important, as the study was focused on current relationships with important others and services and the influences of attachment trauma at present. In parallel to assessing attachment patterns, the ASI also assessed the degree of insecurity of attachment, the specific support context and quality of close relationships, whilst it's qualitative analysis allowed for exploration of additional attachment processes. In contrast, most widely used attachment measures such as questionnaires and other interview measures fail to take into account underlying attachment constructs, personal narratives, level of insecurity or the current support context.

The focus on staff experiences and responses towards service users' insecure

attachment styles is considered to be an additional strength. There has been a relative dearth of studies looking into the interactions between front-line homeless workers and service users, and no study has documented the emotional and cognitive responses of homeless service staff in relation to clients' behavioural processes. This lack of evidence, despite research confirming the high degree of stress and burnout within front-line staff, may be due to the lack of psychological understanding of the experiences of homelessness and the staff who work in the sector (Maguire et al., 2006). In this vein, this project draws attention to the need of applying psychologically-safe practices for both the service users and staff members, including the investment of resources sufficient to support staff adequately.

In regards to the study's limitations, these primarily relate to methodological issues. Recruitment was conducted in two Scottish cities only, and was restricted to the users of day-time services alone (as opposed to the street or shelters). Further to this, only individuals who were not actively psychotic could participate in the ASI (as individuals with psychosis cannot be classified using the ASI). For these reasons, caution must be exercised in generalizing the findings to other homeless populations. Although attachment styles are characterised by universality, the size of the sample does not allow generalization in other populations with potential distinct characteristics (i.e. lower ACE scores, more family support etc.). Furthermore, high attachment avoidance is associated with isolating oneself and minimisation of social contact, therefore individuals with a markedly withdrawn style may have been less inclined to participate in the study.

Another limitation of the study is that no additional behavioural or physiological measures were used to measure the mental health issues experienced by participants. Mental health is a confounding variable with the ACEs, homelessness and attachment styles and the study may have been strengthened from the use of such measures. The exposure to adversity of this group is such that a wide spectrum of problems has carried over in adulthood and manifested in a variety of dysfunctional ways. In this vein, the impact of mental health on a person's functioning may have posed certain restrictions on participation and may have influenced an individual's responses and ability to complete the ACE scale. The study also failed to look at other traumatic experiences at different later life stages, beyond childhood. Although participants gave certain indications in regards to later traumas and mental health difficulties, this has not been measured systematically across the sample. The identification of those variables may have been useful during case analysis.

With regard to causation, although the analysis highlighted some important processes of the role of attachment in developing a pathway into homelessness, the complexity of the phenomenon makes it extremely difficult to isolate specific causal

factors. In this light, a more thorough and systematic exploration of the link between those variables is required. This study, therefore, constitutes a start on that path by exploring attachment insecurity as a general vulnerability to poor individual outcomes, with those depending on specific developmental and environment factors. It makes a theoretical contribution by highlighting the role of attachment in the experiences of MEH population members and offers an explanatory analytical framework for service users' behaviours when engaging with support.

9.4 Implications for practice

Reference to 'difficult to engage' service users features frequently in homelessness literature, however guidance regarding how to manage difficult interactions between service users and staff members in day to day practice is uncommon. In addition, at the moment, there are very few specialist services (Maguire & Ritchie, 2015) in the UK tailored to the needs of individuals with experiences of MEH, and/or mental health services that are accessible. For instance, the vast majority of mental health services in the UK will only accept individuals that have reached a state of 'readiness'. Nonetheless, homeless individuals are often considered 'not ready' and too 'chaotic' to benefit from those services, and are often rejected or turned away prior of any formal assessment. This sense of exclusion can trigger a crisis cycle all over again and prolong episodes of rough sleeping.

A recent international evidence review of what works to end rough sleeping indicated that mainstream responses are ineffective for a great number of those they purport to help (Mackie, Johnsen & Wood, 2019). Given the extensive evidence on the severe and often chronic trauma, substance misuse and mental health difficulties that homeless individuals often face, and the recurrent shared difficulties of staff to support them effectively, it is rather surprising that current mental health services remain so ill-equipped. Further to this, evidence regarding the effectiveness of specific psychotherapeutic approaches in for this client group remains extremely limited. As a result, it is difficult for service providers to discern what intervention (if any) might be most likely to meet their clientele's psychological needs.

The findings of this study indicate that an 'attachment-informed' approach may offer substantial potential in helping services meet the needs of some of the most disadvantaged members of the homeless population. It argues that attachment-based practices can provide a potential whole-service approach that would seem highly fitting to the work of homelessness services. Seager (2014) has previously argued that specific therapy approaches are rather meaningless without taking into consideration individuals'

fundamental and often universal psychological needs, such as secure, trusting relationships, safety and belonging. This would be very much reflected in an attachment-based protocol, such that prior to any form of psychological intervention or therapeutic task, practitioners would aim to establish a secure base that is characterised by emotional connection, regular meetings, genuine and empathic attitude, and full acceptance of service users' psychological state of readiness. In this protocol, the particular relating patterns and attachment experiences of individuals with experience of MEH can be very informative and insightful and might even potentially 'reshape' the current priorities of support services.

In detail, given the high drop-out rates often reported in relation to challenging groups, the transient lifestyle of MEH individuals and the complexity of need, this project suggests that a 'drop-in counselling intervention' embedded in front-line services and supported housing could form the first 'therapeutic relationship' for MEH populations. Service users can gradually establish *psychological contact* as the first condition and pre-condition of any therapeutic relationship (see Rogers, 1957; Prouty, 2007) allowing them to move from pre-expressive or non-expressive to expressive states of communication. Similar to the tenets of the Housing First approach, such a drop in counselling service would not be contingent on readiness, or on 'compliance' on keeping up appointments. Rather, it would be a right-based intervention rooted in a person-centred philosophy, wherein responding to the emotional and psychological needs of homeless individuals is a necessary component.

As the self and attachment difficulties are at the heart of chronic and enduring trauma, especially of ACEs, these must be understood and addressed beyond skill deficits and psychiatric symptomatology. Rather, more emphasis should be given in forming open, secure and trustful relationships with service users with non-mandatory, fixed talking-based components as primary means though which psychological and attachment needs could be met. For instance, a service user could make an appointment with a psychologist on the spot, decide if she/he wants to use the whole therapeutic hour, have a second session within the week and so on. Service users could be further allocated to psychologists on site in order to ensure continuity of the relationship. Intensive effort needs to be invested in removing barriers to access such as poor availability of mental health services, inflexible requirements regarding engagement, excessively rigid care plans and so on. There is an especially pressing need for the kind of flexible and accessible service called for above to support people in mental health crisis interventions.

In this vein, attachment styles may provide an important clinical tool that can guide homelessness service staff members and mental health practitioners' conceptualizations of assessment and intervention strategies when working with individuals who have experience of MEH. Understanding how attachment styles might have evolved as adaptive for service users may allow practitioners to predict likely patterns of interaction, including problematic behaviours and to explain and understand their function. Early identification of highly insecure individuals is considered to be key for increasing the likelihood of more constructive interactions between service users and staff. Those interventions may offset entrenchment of homelessness in the long-term, as service users' attitudes towards staff and services could gradually improve through rebuilding damaged attachment relationships. In encouraging better responses to offers of care, staff may use specific strategies based on distinct characteristics of each attachment style. For instance, highly enmeshed individuals can benefit from encouraging their autonomy and enhancing their ability to cope with anxiety and uncertainty. When overwhelmed by emotions they may benefit from approaches which minimise the focus on emotional distress and provide support, but avoid constant reassurance. In contrast, withdrawn individuals who typically avoid emotional displays and closeness may benefit from interventions which encourage them to verbalise their feelings and interact with others. Staff are called to respond in ways that 'break' those cycles of disengagement. Pushing others away is a response to be expected, as is anger if such individuals are very stressed. Considering their high difficulty in trusting others and services, a predictable framework and provision of information in a clear but not emotionally challenging way could be beneficial.

However, establishing positive interpersonal relationships with service users can be a very demanding task which requires good awareness of relating patterns and behavioural processes on the part of staff. As previously discussed, professionals are called to engage with clients that function based on strong emotions such as anxiety and anger, low self-capacities such as risk-taking and substance misuse (in an effort to manage distress), and high defences such as hostility and denial. Yet, staff are expected to understand and use therapeutic principles in their work without necessarily having the requisite training or knowledge (Phipps et al., 2017). This may lead to potentially unproductive protocol-driven interactions rather than to individualised responses. Furthermore, managing relationships and difficult attitudes impact on staff and can evoke counterproductive reactions, including anxiety or covert hostility and rejection *"despite a wish for open doors"* (Phipps et al., 2017, p. 8). In this light, the attachment perspective can provide valuable theoretical and practical guidance for understanding the needs of service users in relationships, the basis

of any defensive behaviours and the reciprocal influences of service users and staff upon the relationships that develop.

Following from this, findings suggested that the vast majority of participants lacked the ability to self-sooth and seek support effectively in times of need. This further supports Adshead's (2001) contention that members of challenging populations can long for secure attachments but struggle to elicit care from professional caregivers in fruitful ways or to know how to respond to it even when it is offered by a competent caregiver. As a way to address those difficulties and work effectively with distressed individuals, a space to reflect and be supported is required, as has been suggested by Carson and Dennison (2008). Building secure and consistent relationships requires 'containing and holding' the emotional experience of service users, but also that of support staff. Attachment theory offers an overall practice approach to suit service users' style that can guide day to day interactions with staff members, but also assist in developing a reflective capacity and improve staff self-efficacy via establishing regular reflective practices (in addition to supervision and training).

Within an attachment framework, trauma-informed reflective practices are considered to be key. It is accepted and expected that staff members will have their own triggers, hotspots and stressors which can be activated, re-surfaced and re-enacted within their work considering service users' pervasive experience of trauma. Reflective practices can help staff to make changes in the way they interact with service users, experiment with different responses, mentalize [4] thoughts and feelings, and vocalise tensions around their role and practice. It has been previously suggested that key working is often a "take for granted model of practice" (Holt & Kirwan, 2012, p. 389) with staff struggling to reconcile their role as an active helper and reflective practitioner. Staff could benefit from updating and redefining their skills and theoretical base if provided with regular opportunities to reflect on their work and support the complex task of building relationships. Similar to previous research reporting that formulation groups can increase staff self-efficacy (Maguire, 2009), this project suggests that reflective practice should be prioritised as a meaningful process and as an integral part of current practise within the homeless sector.

In line with the above implications for practise, the attachment perspective also shares common ground with the PIE approach that is increasingly applied in homeless

[4] "Mentalization, or better mentalizing, is the process by which we make sense of each other and ourselves, implicitly and explicitly, in terms of subjective states and mental processes. It is a profoundly social construct in the sense that we are attentive to the mental states of those we are with, physically or psychologically" (Bateman & Fonagy, 2010, p. 11)

services. A PIE is considered to be a 'broadly therapeutic intervention', 'by definition idiosyncratic' and 'nuanced' (Phipps et al., 2017, p. 13). Although it provides a content of a valued environment, it is yet lacking explicit and concrete practical guidance regarding how to implement it, and has been further questioned of its lack of clarity regarding what psychology's contribution should be. This study offers both theoretical and some practical suggestions which may be helpful in informing its operationalisation within the homeless sector. In particular, PIEs are conceptualised through an attachment perspective, whilst it is suggested that attachment based approaches should be incorporated into PIEs in order for them to be meaningful for staff and services. Attachment theory can make a novel contribution to current practices in homeless services and allow staff to identify behaviours and tendencies in a more consistent and 'predicable' manner. This would enhance staff members' understanding of the factors underpinning specific ('challenging') behaviours, help them avoid provoking negative reactions from service users and, importantly, better equip them to relate in ways that will foster positive staff-user relationships. Such approaches may thus increase the palatability of support to individuals with experience of MEH who would otherwise actively avoid or reject it.

Evidently, any psychological practices should be seen along the continuum from the difficult and challenging toward a sense of greater mental well-being. However, as Phipps et al. (2017, p. 12) has noted, fragmented service provision and short-term contracts in increasingly marketised social care systems, as exist within the UK, conflict with "the long-term process of rehoming and rebuilding damaged attachments". The argument that current health care services in the UK provide an equal access to all groups regardless of their status appear to fall short given the short-term and often behavioural-focused counselling provision and inflexible admission requirements, such as the abstinence-only philosophy. In reality, establishing a healthy attachment relationship "must precede any attempts to rehabilitation" (Seager, 2011, p. 186). As in any psychological or clinical intervention that is considered to be successful, deeper bonds of trust and attachment are required. To achieve this, services should adopt proactive and flexible interventions adjusted to a 'chaotic lifestyle' (i.e. place psychologists on site, set up drop in counselling services and reflective practices, adopt attachment related interventions etc.), focus on establishing psychological connections and avoid constant assessments and fixed entry criteria. This is also supported by evidence that confirms the effectiveness of "assertive outreach", which very proactively and persistently encourages and supports rough sleepers to "come inside" and engage with support services (Mackie et al, 2019).

Finally, it might be argued that a key learning from the study regarding the utility of an attachment perspective in informing interventions with vulnerable people may be transferable to a range of different policy and practice contexts, from mental health to education. Attachment offers a generalised and context-informed framework for the relationship with care which can be translated and have an influence over a variety of practices by professionals who work with vulnerable adults and children. Evidence suggest that throughout the lifespan individuals can develop various context-specific attachment bonds with a number of individuals, including therapists, colleagues, teachers, GPs, social workers and so on. Applying what we know about attachment in adulthood to the relationship with services, 'extracting' attachment-related information that may manifest in a given context and inform the design and development of services is considered to be a tangible implication for practice that requires further attention.

9.5 Directions for future research

The thesis highlighted several avenues that would benefit from further exploration. First, future research should consider assessing the attachment styles of staff members. Evidence suggest that staff perceptions towards service users' behaviours may be influenced by their own attachment styles (Berry et al., 2008). For instance, professionals' insecure styles have been shown to be related to difficulties in empathising with others (Britton & Fuendeling, 2005). As a result, others' behaviours can easily be interpreted as chaotic and non-understandable (Barber et al., 2006). In other words, anxious or avoidant staff may be less insightful concerning service users' needs, while their responses to work stress may differ altogether. It would be interesting to investigate correlations between professionals' attachment styles and approaches to service users, as they may be influential in the development of better quality staff and service user relationships by making staff more aware of their own reactions and potential biases.

Despite the findings on the influence of attachment styles on capacity to make use of social support, a longitudinal study of attachment styles (possibly using a quantitative methodology) would be useful to evaluate the link between relating processes, mental health and emotion regulation strategies over a period of time. Emotion regulation is a core principle of attachment, in that individual differences in emotion regulation strategies are shaped by attachment experiences. It is a useful concept and a psychological mechanism that underpins mental health difficulties in clinical and subclinical populations. Understanding how homeless individuals regulate their emotions during high points of distress and what strategies they used to achieve their goals may enhance a more complete

understanding of factors that interplay. In this respect, research ascertaining how emotion regulation strategies and mental health affect engagement with services amongst homeless individuals offers substantial potential.

Future research should also consider using a larger sample, which would assist in improving generalizability of the above findings and allow for greater exploration of gender differences in attachment needs and relationships. Moreover, future designs could be expanded by using an attachment to place measure, such as the Service Attachment Questionnaire (SAQ), which assesses the ability of a mental health service to meet the attachment needs of its' service users (Goodwin et al., 2003). Professionals may serve as temporary attachment figures by stimulating secure attachments via sensitive and appropriate responses to distress and consistency of input, however attachment is not only developed at an individual level. Goodwin et al. (2003, p. 146) suggest that in many services people may be allocated to teams (due to shift-work, high staff turn-over etc.) rather than having an allocated key-worker, *"hence purport that it might be more appropriate to think of a 'team' or 'service to client' attachment"*. The SAQ encompasses aspects of attachment that reflect what service users find helpful and unhelpful in services, the availability and responsiveness of professionals, the importance of consistency and continuity, as well as questions related to trust and respect. The questionnaire could be adapted for use in homeless services and potentially assist in enhancing and reforming service approaches.

Finally, a general framework for defining and evaluating attachment based approaches in homeless services is necessary. Future research should consider how this framework might meet the complex needs of homeless populations (for instance by having an addiction worker on site at all times), and establish appropriate interventions techniques and goals. Staff in homeless services could benefit tremendously from understanding interpersonal aspects of service user-staff encounters and assessing distressed attachment bonds. For instance, by knowing how to apply a service user-centred behavioural intervention such as an anxiety reducing and grounding approach aimed at resolving conflict or ambivalence to engagement. Despite various studies linking attachment behaviours and styles to clinical outcomes (i.e. substance use), as of yet, very little attention has been given at implementing those lessons in the routine practice of services that work with homeless people. Such a framework may prove to be pivotal in promoting client-centred, cost effective and value-based care thereby giving service users greater cause to take the risk of trusting in a service provider.

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APPENDICES

APPENDIX A: Demographics Questionnaire.

Source: Census survey, 2010

1. What is your current age? _____
2. What is your gender? _____
3. How would you describe your ethnic background? _____
4. What is your relationship status? **(please tick a box)**

☐ Single ☐ Married ☐ In a relationship ☐ Separated ☐ Widowed

5. What is your current circumstance with regards to accommodation?

☐ Staying in homeless hostel ☐ Staying in long-term accommodation

☐ Staying in a shelter ☐ Staying in a B&B hotels ☐ Sleeping rough

☐ Staying with friends/relatives ('sofa-surfing') ☐ Other _____

6. How old were you when you first became homeless? Approximate age _____
7. How many different times you have been homeless? Approximately _____ times.
8. If homeless now, how long have you been homeless this time? Approximately _____

9. Did you have a period in life when you: (**tick all that apply**)

☐ had six or more alcoholic drinks on a daily basis ☐ used hard drugs

☐ injected drugs ☐ abused solvents, gas or glue

☐ went to prison ☐ lived in local authority care

☐ were admitted to hospital because of a mental health issue

☐ begged ☐ were involved in street drinking

☐ shoplifted (because you needed things like food, drugs, alcohol, or money for somewhere to stay

APPENDIX B: Adverse Childhood Questionnaire (ACE) ra hbr 10 24 06

Source: CDC-Kaiser, The Childhood Experiences (ACE) Study (1998).

While you were growing up, during your first 18 years of life:	**YES**	**NO**
1. Did a parent or other adult in the household **often** wear at you, insult you, put you down, or humiliate you? **OR** Act in a way that made you afraid that you might be physically hurt?	☐	☐
Push, grab, slap, or throw something at you? **OR** Ever hit you so hard that you had marks or were injured?	☐	☐
2. Did an adult or person at least 5 years older than you **ever**…		
Touch or fondle you or have you touch their body in a sexual way? **OR** Try to or actually have oral, anal, or vaginal sex with you?	☐	☐
3. Did you **often** feel that…		
No one in your family loved you or thought you were important or special? **OR** Your family didn't look out for each other, feel close to each other, or support each other?	☐	☐
4. Did you **often** feel that…		
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **OR** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	☐	☐
5. Were your parents **ever** separated or divorced?	☐	☐
6. Was your mother or stepmother:		
Often pushed, grabbed, slapped, or had something thrown at her? **Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard? **Ever** repeatedly hit over at least as few minutes or threatened with a gun or knife?	☐	☐
7. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	☐	☐
8. Was a household member depressed or mentally ill or did a household member attempt suicide?	☐	☐
9. Did a household member go to prison?	☐	☐

APPENDIX C: Summary of the Adult Attachment Instruments Reviewed

Attachment Instruments	Relationship Focus	Type of Assessment and Categories/Dimensions Measured	Analysis
Adult Attachment Interview (AAI)	Parent –child relationship	• Assess mental representations of attachment while discussing childhood experiences • Yields attachment styles (categories)	Discourse and Narrative analysis
Attachment Style Interview (ASI)	Any close relationship	• Assess support context and quality of close relationships • Yields attachment styles (categories)	Scoring is based on manualized benchmarks examples. Attitudinal scales are coded together to obtain an overall quantitative assessment for the quality of each relationship and used to categorise attachment style.
Reciprocal Questionnaire (RQ)	Partner or general	• Assess attachment style based on four short paragraphs that corresponding to each attachment style • Yields attachment styles (categories)	Rating according to a 7-point scale (Participants rate the degree they resemble each style)

Relationship Style Questionnaire (RSQ)	Partner	• Assess attachment style • Yields attachment styles (categories)	30-item scale Participants rate the extend that each statement best describes their relating style in close relationships on a 5 point Likert scale
Experiences in Close Relationships (ECR) and revised version (ECR-R)	Partner (or general if modified)	• Assess attachment style • Yield attachment styles and attachment dimensions (avoidance/anxiety)	36- item scale; 18 items correspond to attachment avoidance 18 items correspond to attachment anxiety
Adult Attachment Scale (AAS) and revised version (RAAS)	Partner	• Assess quality of close interpersonal relationships • Yields dimensions of closeness and dependency (can also yield categories)	18- item scale Each statement is rated on a 5 point Likert scale

Attachment Style Questionnaire (ASQ)	Close relationships	• Assess attachment style • Yields dimensions of attachment avoidance and attachment anxiety	40- item scale. Participants rate aspects of themselves and others on a 6 point Likert scale
Vulnerable Attachment Style Questionnaire (VASQ)	Relationship with support	• Assess degree of vulnerability to psychopathology based on attachment characteristics • Yields dimensions of insecure attachment or proximity seeking	22- item scale Each statement is rated on a 5-point Likert Scale
Reciprocal Attachment Questionnaire for Adults (RAQA)	Most important attachment figure	• Assess quality of individuals' most important attachment figure • Yields dimensions of attachment anxiety or attachment avoidance	Scoring is based on predetermined scales (Proximity seeking, separation protest, feared loss, perceived availability, angry withdrawal, compulsive care giving, self-reliance, and care seeking)

The assessment of attachment styles has been quite controversial and extensive in research with a variety of research methods being available. Those derive primarily from the developmental, or psychosocial approach and tend to 'compete' with one another (see George & West, 1999; Belsky, 2002; Mikulincer et al., 2003; Ravitz et al., 2009). The long

lasting debate has focused on both the assessment tools used for measuring attachment (interviews versus self-report questionnaires) and the exact concept that they tend to examine (styles versus attachment dimensions). In other words, although both approaches were developed based on the main concepts of attachment theory, they tend to differ in their scoring systems, the constructs that they are interested in, and their relationship focus. Furthermore, measurement and conceptualisation of attachment has been polarised into those that examine developmental and psychodynamic aspects of attachment (relationship to parenting and children's experience) and those that explore romantic relationships, mental health difficulties and adult support capacity (Shaver &Mikulincer, 2002).

Bifulco (2008) argues that prior to selection of an attachment instrument, particular emphasis should be placed on the practice implications and inferences that can be drawn from the assessment tool. In particular, she asserts that *"standardised procedures and predetermined benchmarks are critical for justifying complex practised-based judgements and decisions"* (Bifulco, 2008, p. 36). For instance, self-report questionnaires due to their nature (quick and face valued) could be challenging in justifying such decisions when compared to more comprehensive measures (Bifulco, 2008).

The most commonly used interview measure of adult attachment is the Adult Attachment Interview (AAI) developed by Ainsworth et al (1978). The interview assesses the attachment styles based on parent-child relationships and early life experiences. AAI is considered to be the gold standard of attachment measures and has been extensively used in predicting the quality of parent-child interactions. A great number of studies have used the AAI with clinical (see indicative reviews; Van IJzendoorn et al., 1996; Agrawal et al., 2004; Daniel, 2006; Kuipers et al., 2012) and non-clinical samples (see relevant reviews; Berry et al., 2006; Bakermans-Kranenburg et al., 2009). The interview differs from all other measures given the fact that is analysed via discourse and narrative techniques which focus on the degree of coherence, personal style and defensive processes that emerge during the assessment. As opposed to the developmental psychology perspective that underpins the AAI, self-report questionnaires are primarily deriving from the social psychology approach. In contrast with the AAI, most self–report questionnaires tend to focus on feelings and behaviours in present relationships, especially romantic ones, assess conscious processes, and be quick in their application.

Further to this, research suggests that most self-report questionnaires measure attachment in terms of continuous dimensions when compared to interview processes. In particular, their analysis often focuses on two underling dimensions of relationships; the avoidance and anxiety dimensions (Brennan et al., 1998). Different methods of assessing

attachment style emphasize different attachment phenomena therefore the choice of a measure is highly dependent upon how relevant is the kind of relationship, or the attachment related-processes that are under investigation. For instance, if the focus is on relationship-related behaviours under stressful circumstances as experienced and reported by the person then self-report measures are more likely to be a more appropriate assessment technique. In contrast, if the focus is on childhood attachment relationships and the meaning that the individual currently gives to past experiences, then the AAI might be a more suitable measure.

Appendix D: Attachment Style Interview (ASI) – Part 1 (Relationship with VCO's)

Source: The Attachment Style Interview for Research and Practise (ASI-RCP). Centre for Abuse and Trauma Studies, Middlesex University, (2008).

	Do you confide in partner/VCOx? If not at all, why is that?
Confiding	What sort of things do you tell him/her? Do you just touch on it, or can you go into detail?
	Do you tell him/her your most personal feelings? Have you done this recently? What did you say? Can you confide problems with health, money, or emotional issues?
	Is there anything you would not tell him/her? Why is that?
Active Emotional Support	Do you think s/he is interested when you confide or not particularly?
	What does s/he say or do when you confide? Does s/he listen? In what way? Does s/he take your side or is s/he a bit critical? Does s/he offer any advice?
	Have you confided in him/her recently about anything? (Refer to life events/difficulties/crisis based on the life events questionnaire)
Actual confiding	When (life event) happened, did you talk to Partner/VCOx about it? What did you say to them? How much detail did you go into? What did you say about your feelings or worries? How did they respond when you talked to him/her- what did they actually say? Did what they say help you? In what way?
Positive quality of interaction	Do you and partner/VCOx manage to spend any time alone together? What is it like when you are alone together? (Relaxed? Quiet? Tense? Fun? Joking? Arguing?)
	Can you describe for me what you did one-week night last week?

Negative interaction	What kinds of things make you irritable with each other? (Do you have a go at each other, when you are niggled, or do you bottle it up? What about your last quarrel? What happened?) If yes, how often does this happen, say over the last month? Do arguments ever become violent at all – where one of you throws things or hits the other? (Is this often? Has this ever happened in the past? When was that?) Many relationships have had patches from time to time when they are not getting on or where one partner considers leaving. Have you had times like this? If yes, when was this? What happened?
Felt Attachment	Do you rely on partner/VCOx? Do you think you could manage without him/her? Easily? How would you feel if s/he was not there? (A bit lost? Afraid? Uneasy?) Are there any kinds of situation where you feel you just could not rely on him/her? How close would you say you currently feel to partner/VCOx?

Appendix D: Attachment Style Interview (ASI) – Part 2 (Attitudinal aspects)

Source: The Attachment Style Interview for Research and Practise (ASI-RCP). Centre for Abuse and Trauma Studies, Middlesex University, (2008).

Mistrust	Do you find it hard to trust other people? Do you often feel suspicious of people? Do you tend to question people's motives? Why? Do you find it hard to trust people close to you? Why is that do you think? Do you ever feel people are against you? In what way? Do you feel most people are out for themselves? Why do you think that?
Constraints on closeness	Is having someone close important to you? If not, why? Do you find it hard to get very close to people? If yes, is that the same for most people of just some people you know? Why do you think this is? Do you find it difficult to confide in people? Why do you think this is? Do you find it easy to ask people for help? Can you go to others for advice if you have a problem? Are there any particular people you would not go for help? For example, family, friends? Why is that?
Fear of rejection	Do you feel you cannot trust others in case they let you down? Why do you think that? Have you ever been badly let down by someone? Does it ever make you feel uncomfortable to be too close to people? If yes, why is that? How do you feel when someone wants to confide in you? Do you ever feel uneasy? If yes, why is that? Have you ever regretted being open? Have you ever felt hurt or rejected by anyone you have been close to? Does the fear of being hurt stop you getting too close to people? If yes, is it for most people or some?

Self-reliance	Do you feel you generally cope well with your problems? Do you usually feel you cope better on your own or with others' help? Is it important to you to be independent? Would you describe yourself a bit of a 'loner', or do you like getting advice from others? Do you rely on the advice of friends in making up your mind? Or not really? Are other people's opinions important to you? How do you feel when others are critical of you? Can you make decisions easily without other people's help? Is it important for you to feel you have control over your life? How do you feel when things do not go the way you plan them?
Desire for company	Would you say you are a sociable person? Do you enjoy meeting new people? Is it important to you to have people around you a lot of the time? Does being alone bother you? If yes, how does it make you feel? In what sort of situations? Do you ever feel you see too much of your friends of family? Do you ever feel like distancing yourself from them? If yes, why is that? Do you tend to enjoy your own company- or can you get lonely without other people around you all the time? Would you like to see acquaintances or more distant relatives more regularly?
Fear of rejection	Do you think you are a possessive person? Do you get anxious when people close to you are away? What if it is only for a short period? Do you find it difficult to say goodbye to people? How about when someone in your family gets back later than expected, do you worry a lot? What would you miss most if your partner were not there for some reason?

Anger	Do you often fall out with people/acquaintances? Can you give me an example? Do you often get into arguments? If yes, what tends to happen? Do you ever feel resentful about the past in general? For example, your childhood experiences? Do you ever feel people have not done enough for you? Do you feel taken for granted?
Ability to make and maintain relationships	Do you feel you are good at making relationships and if yes, in what ways? If no, why is that?

APPENDIX E: Recent Life Events Questionnaire (modified version)

Source: Brugha, T., Bebington, P., Tennant C & Hurry, J. (1985)

Here I have a list which covers a number of events that may have happened to you over the last year. I am asking about those events, as they may be the sort of things you would talk to a close friend and family about. I will read each possible life event out loud and please tell me if the event occurred and if it still affects your life.

	Yes	No
Have you had a serious illness or been seriously injured? (Prompt around experiences of overdosing)	☐	☐
Has someone close to you been seriously ill or injured?	☐	☐
Have you had any major mental health difficulties?	☐	☐
Have any of your immediate family or a close other passed away?	☐	☐
Have you (or an immediate family member) been subject to serious attack, abuse, or threat?	☐	☐
Have you had any serious problems or been separated with a spouse or partner?	☐	☐
Have you had any major financial difficulties (e.g. debts, benefit sanctions)?	☐	☐
	☐	☐

NOTES:

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……

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VCOs:

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APPENDIX F: Follow-on interview

Source: A follow on interview questions and prompts focusing on the relationship with existing services, was developed in consultation with the supervisors for the purposes of the study.

Introduction: What I am really interested in is understanding the effects of relationships on the individuals, so I am very keen to know what do you think about the following questions:

1. **Do you think that your relationships with others (in general) played a role in you becoming homeless? Why do you think this is?**

2. **Do you think that the way you relate to others and they relate to you has had any impact on you remaining homeless?** (Prompt; if so, why do you think your relationships with others have played a role in keeping you on the streets?)

Degree, level, and quality of client engagement with services

3. **Which services did you mostly use over the last year?** How often do you make use of those services? (If unclear, what do you use the services for?)

4. **How would you describe your relationship with the services**? (Prompts; what is the relationship like at first? What is the relationship like while you use the service? How does the relationship develop? How did the relationships with x and x service end? What was it like for you? What influenced your decision to leave/terminate contact with x service?)

Clients' attitudes towards care/interventions/help

5. **How do you react when you are offered support/help by services?**

6. **How do you react when the type of help is not what you hoped for?** (Prompt; what if it does not happen right away?)
7. **Have you refused support that has been offered in the past? (**Prompts; why is this? Do you find it difficult to make use the support offered? Any examples? Or are there any agencies that you wouldn't go for help?)

Clients' attitudes towards workers

8. **How well do you get on with staff members?** (Prompts; What is your communication like with staff members?)

9. **Do you confide in them? Do you feel you can confide things like your housing situation, substance misuse, and mental health? Is there anything you would not share? Why is that?**

10. **Do you feel that they understand your needs and problems?** (Prompt; Do you feel you have a partnership with your support worker and that you work together?)

11. **Do you rely on your support worker/service? Do you think you could manage without them/it?** (Do you rely on them for making up your mind?)

12. **Are there any times that you would think they have failed you? If yes, in what way?**

13. **Do you think that support workers see you as easy to work with or difficult to work with or somewhere in the middle? Why is this? Any examples?** (Alternatively; Do you think that staff members find it hard to approach you/work with you? On a scale of 1-10 with 1 being easy to work with and 10 really hard to work with, where do you think you stand?)

Closing questions

14. **Is there anything that the service could do better to meet your needs?**

15. **Is there anything that you would like to add?**

APPENDIX G: Vignettes for focus group

Source: The storyline of the following vignettes was developed on the basis of previous research findings related to five distinct attachment styles in adulthood (Bifulco et al., 2002; 2008; 2012). A vignette for a secure attachment style was not developed based on the focus of the study on challenging and difficult behaviours.

Introduction

What I am really interested in is your experience if you were coming across the situations described in the vignettes. What you would realistically do/think/feel/say? What is your decision-making process and approach?

Vignette 1 (Avoidant dimension: withdrawn style)

A female service user has a drug addiction and has been rough sleeping for 5 months. She is accessing homeless and crisis services almost on a daily basis to use basic facilities. She is always guarded and suspicious of others, and she does not really engage with staff members (e.g. makes minimal eye-contact), beyond small talk. Staff would describe her as always having a smile on her face and that she seems to know what she is doing and what she needs. In their interactions, it is observed that she will have a positive view on things and often minimises her problems. Staff try to offer support with her housing situation but she has now missed three appointments with the housing officers.

Vignette 2 (Avoidant dimension: Angry dismissive style)

A 56-year-old male who has been homeless for more than a decade. He is a familiar face to most services and is in and out of homeless hostels. He has previously lost his accommodation over drinking and antisocial behaviour. When asked about his housing situation, he states that he does not need any support or help with it. He will often have arguments with staff members and other professionals and has been excluded by a number of services due to behavioural issues. Staff members describe him as volatile, with poor impulse control, and consider him a 'loner'. When in a good mood, the client will often make jokes and laugh at things.

Vignette 3 (Anxious dimension: Enmeshed style)

A 24-year-old homeless male, who after two years of living on the streets, has recently moved to temporary accommodation. The client is a heroin addict and has been diagnosed with depression. He does not make use of any services and was initially spotted and approached on outreach. The client says that he is fearful of others that make use of those services. After missing a number of appointments, the client has managed to attend the housing and GP appointments after regular prompting, but even then only when accompanied by a staff member. During appointments, he seems lost, overwhelmed, and scared. Staff members say that he seems very vulnerable and they will often spend a lot of time with him offering emotional support.

Vignette 4 (anxious dimension: fearful style)

The client is a 19-year-old homeless male diagnosed with bi-polar disorder. He was adopted at an early age, experienced physical abuse, and in his early teens was transferred to another family. After an argument with his foster parents he left home, sofa surfed for some time and ended up in the streets. He uses crisis services very rarely and when he does he is

visibly distressed. He uses drugs to self-medicate. For a period of time, he started engaging more with staff and making progress toward resolving his housing situation. During this phase he was described as being open to discuss his difficulties, but also 'shaky' and kind of frightened when doing so. He then disappeared for more than a month and when he re-appeared, he had a number of wounds possibly resulting from self-harm. He denies self-harm and when asked about the incident he says that this is what he is like.

APPENDIX H: Topic Guide and Prompts for Focus Groups Discussions

Source: A topic guide with questions and prompts focusing on how staff members make sense of the given vignettes was developed in consultation with the supervisors for the purposes of the study.

1. What is your understanding about the ways in which this person relates to the services described? (How might you understand those ways?)

2. In what sort of ways do you think you might end up interacting with this service user? Or How would you engage or interact with them? Why? (How would you expect to react to the situation?)

3. Can you say what might lead you to respond this way? (Why do you think you may behave like this?)

4. What do you think would be the major challenges for you as someone trying to work with this service user?

5. How do you think this sort of behaviour might make you feel? What do you think it is about the behaviour that might make you feel this way?

6. What challenges/issues does this behaviour present to you as a front-line practitioner?

7. What do you think is the impact of your emotional reaction on the way that the service user acts? Does it help? Does it hinder?

8. Is there anything you think the service could do differently that might help the service user make fuller use of what is available? (What do you think is needed to try help them engage more constructively with the support your service offers? What could you and what could the service do to facilitate this?)

APPENDIX I: Consent form for participants

A study exploring the experiences of people that have experienced multiple exclusion homelessness in the UK.

The nature and purpose of the study have been explained to me. I understand that I will not be identified in any reports resulting from the research, that I can refuse to answer any questions, and can stop the interview at any time. If I choose to withdraw, this will not affect my access to services.

Please initial the box(es) if you agree with the statement(s):

I agree to take part in the study.

I give my permission for the interview to be recorded.

Name of participant (print name) ……

Signature of participant……

Date……
…

Researcher's name:
…….....

Researcher's signature:
…….....

APPENDIX J: Information sheet for focus group participants

Institute for Social Policy,
Housing and Equalities Research
Heriot-Watt University

A study exploring the experiences of people that have experienced multiple exclusion homelessness in the UK

Information Sheet for focus group participants

My name is Nikoletta Theodorou and I am a PhD student at Heriot-Watt University. If your work involves regular direct interactions with people experiencing homelessness I would be very grateful if you would consider participating in a focus group discussion as part of my doctoral research.

What is the study about?

The study examines the nature of relationships between multiply excluded homeless people and support services. In particular, I am interested in exploring how staff members make sense of and respond to the so-called 'chaotic' and 'challenging' behaviours that a number of service users may exhibit when seeking and engaging (or not) with support. The findings will be used to reflect on whether and if so how support services might potentially improve the way they work with this particular client group.

What is involved?

If you agree to participate, I will invite you to take part in a group discussion along with other members of staff. During this, I will ask you about your experiences when working with this client group and we will be making use of hypothetical scenario cases (vignettes) to explore practices and strategies in context. Please note that there are no right or wrong answers in a discussion of this kind – I am simply interested in your experiences and perspectives.

The group is likely to involve approximately 4-6 participants, and it will take around an hour and a half. Discussions will take place at a convenient time and place for those involved.

If everyone who volunteers to take part agrees, I will record the discussion. The recording will only be used for research purposes and will not be heard by or made available to any third party. All of the information you provide will remain confidential and no outputs from the study will include your name or any other identifying characteristics.

Do I have to take part?

No, participation is entirely voluntary. Most people find the experience of taking part in a discussion like this interesting and stimulating. However, you are free to take a break at any time, decline to answer any particular questions, or to withdraw from the discussion altogether should you wish to do so.

Where can I get further information?

If you have any questions at all about this study, please feel free to contact me: Nikoletta Theodorou at nt14@hw.ac.uk. The study is supervised by Professor Sarah Johnsen, Dr Beth Watts and Dr Adam Burley. For any further inquiries, you may also contact:

Professor Sarah Johnsen
Institute for Social Policy, Housing and Equalities Research (I-SPHERE)
Heriot-Watt University
Riccarton
Edinburgh
EH14 4AS
P: 0131 451 3642
E: s.johnsen@hw.ac.uk

APPENDIX K: Information Sheet for interview participants

Institute for Social Policy,
Housing and Equalities Research
Heriot-Watt University

A study exploring the experiences of people that have experienced multiple exclusion homelessness in the UK

Information Sheet for interview participants

My name is Nikoletta Theodorou and I am a PhD student at Heriot-Watt University. Given your experience of using this (and possibly other) services, I would be very grateful if you would consider taking part in an interview as part of my research.

What is the study about?

The study explores how people who have experienced homelessness relate to and use support services. It also considers the role that relationships play in the causation of homelessness.

What is involved?

If you agree to participate in this study, I will ask you to take part in a face-to-face interview, which will take between one and two hours. This will consist of being asked questions about your current relationships, your general style of relating to other people, and your relationships with services. You will also be asked to fill in a short questionnaire about childhood experiences. You may choose to complete the questionnaire yourself, or ask me to help you.

Your interview will be audio-recorded. All of the information you provide will remain confidential and accessible only to me. Reports from the study will not include your name or any other identifying characteristics. Everyone who takes part in the study will be given a £20 voucher to thank them for their contribution.

Do I have to take part?

No, participation is entirely voluntary. You can change your mind and withdraw from the study at any time or refuse to answer any questions without giving a reason. Your decision about whether or not to take part in the research will not affect the services you receive in any way.

What happens when the study is finished?

All of the audio recordings will be destroyed and the transcripts from the interviews will be stored securely in line with Heriot-Watt University's data management policy. The findings of the study will be written up in a thesis, published in journal articles, and presented at conferences. You will not be identified in any of these outputs.

What are the possible benefits and disadvantages of taking part?

Whilst there are no direct benefits of participating in the research, some participants appreciate the opportunity for reflecting on personal issues with someone they do not know, in a setting that is bound by confidentiality. In addition, by participating in this study you

will be contributing to knowledge of how services can most effectively meet the needs of people who use them.

Some of the questions are personal and sensitive in nature and cover topics like difficult childhood experiences and personal relationships. You do not have to answer any questions that you do not want to, and if you experience any sense of unease during the interview, you may withdraw at any time, and a member of staff may be contacted to offer you further support. Contact numbers of available counselling services will also be given, if requested.

Where can I get further information?

If you have any questions about this study, please feel free to contact me: Nikoletta Theodorou at nt14@hw.ac.uk or alternatively, you can ask the service to contact me. The study is supervised by Professor Sarah Johnsen, Dr Beth Watts and Dr Adam Burley. For any further inquiries, you may also contact:

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